EVALUATING THE EFFECTIVENESS OF A TRANSGENDER-AFFIRMATIVE CARE TRAINING ON HEALTHCARE WORKERS’ AND TRAINEES’ ATTITUDES TOWARD AND KNOWLEDGE OF ROUTINE CARE AND TRANSITION SUPPORT FOR TRANSGENDER INDIVIDUALS

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EVALUATING THE EFFECTIVENESS OF A TRANSGENDER-AFFIRMATIVE CARE TRAINING ON HEALTHCARE WORKERS’ AND TRAINEES’ ATTITUDES TOWARD AND KNOWLEDGE OF ROUTINE CARE AND TRANSITION SUPPORT FOR TRANSGENDER INDIVIDUALS

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Dissertation

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Evaluating the Effectiveness of a Transgender-Affirmative Care Training on Healthcare Workers’ and Trainees’ Attitudes Toward and Knowledge of Routine Care and Transition Support for Transgender Individuals

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Objectives: Transgender individuals, often highly stigmatized and discriminated against, face challenging barriers regarding seeking routine- and transition-related physical and mental health care (James et al., 2016). What has been consistent throughout time is that contact as an intervention (i.e., personal contact, contact with educational materials, and/or contact with general media outlets) has been found to be associated with improved attitudes toward and knowledge of marginalized communities (Braun et al., 2017; Click et al., 2019; Reed, 2018; Stroumsa et al., 2019). The aim of the current study was to explore the impact contact with a transgender-affirmative care training may have on healthcare workers’ and trainees’ attitudes toward and knowledge of routine care and transition support for transgender individuals.

Methods: Healthcare workers and trainees were recruited for participation through their workplace. Participants attended either an in-person (i.e., Study 1) or virtual (i.e., Study 2) training on transgender-affirmative care, and completed a pre- and post-training survey, as well as a 3-month follow-up survey. The surveys were comprised of a general demographic questionnaire, an Awareness of Transgender Topics Measure, the Anti-Transgender Prejudice Scale (Reed, 2018), and open-ended response options.

Results: Analyses revealed partial support for two of the three hypotheses for Study 1 and 2. Independent-samples t-tests comparing means for the dependent variable of anti-transgender prejudice by prior contact at the pre-training survey measurement did not yield significant differences. However, when samples were combined, analyses did reveal significant differences. Paired samples t-tests comparing the means for dependent variables of anti-transgender prejudice and awareness of transgender topics by time (i.e., before and after the training) partially revealed significant differences. Participants’ immediate post-training measurement, when compared to their pre-survey measurement, demonstrated a significantly lower average rating on the ATPS and higher average rating on the ATTM, but this was not consistent for immediate post-training measurements compared to their 3-month follow-up measurement. However, scores at the 3-month follow-up did demonstrate a general decrease in prejudice and increase in knowledge compared to baseline measurements.

Conclusion: The findings from the current study, despite the limitations, support the need for continued education on transgender topics, as well advocating for an increase in personal, educational, and general media contact as it relates to transgender individuals and/or their unique
experiences, to improve the attitudes toward and knowledge of routine care and transition support for transgender individuals.
Dedication

This manuscript is dedicated to my beautiful wife, Emily Reed. I cannot thank you enough for your unconditional love and your wholehearted trust in joining me on the journey of a lifetime while pursuing a PhD and completing my dissertation. This degree pathway certainly is not a sprint; rather, it has been the longest marathon we have faced. The milestones of this degree have oddly mirrored the stages of our actual marathon experience: 1) nervous excitement (first day, starting line); 2) feeling invincible (year one, miles 1-10); 3) reality check (years 2-3, miles 11-13); 4) second wind (year 4, miles 14-18); 5) the wall (year 5, miles 19-22); 6) end is in sight (year 6, miles 23-25); and 7) finish line (defense/graduation, mile 26.2). I choose you every day to be my marathon partner, both literally and figuratively. Lace up for the next chapter.
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Lastly, thank you to Missoula and the surrounding mountains. You reminded me that professional success is meaningless unless it is balanced with personal adventures. The place that a river runs through it will forever hold a special place in my heart.
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Evaluating the Effectiveness of a Transgender-Affirmative Care Training on Healthcare Workers’ and Trainees’ Attitudes Toward and Knowledge of Routine Care and Transition Support for Transgender Individuals

Introduction

Transgender individuals, often highly stigmatized and discriminated against, face multiple barriers when it comes to being affirmed within their gender identity. A particularly challenging barrier regards seeking routine- and transition-related physical and mental health care. It has been found that transgender individuals, compared to people from other highly stigmatized minority groups, experience some of the highest levels of stigmatization, prejudice, and discrimination (Dispenza, Warson, Chung, Brack, 2012; Grant et al., 2011; Hughto, Reisner, & Pachankis, 2015; James et al., 2016; Stotzer, 2009; Walch, Ngamake, Francisco, Stitt, & Shingler, 2013). These negative attitudes and behaviors permeate into several areas of life for transgender individuals, including experiences faced while seeking physical and mental health care. Although the training healthcare workers and trainees receive has improved throughout the years regarding working with sexual and gender minority individuals (Lim, Johnson, Eliason, 2015; Obedin-Maliver et al., 2011; Sequeira, Chakraborti, Panunti, 2012), it is evident that there are still significant training gaps regarding how to affirmatively care for transgender patients (i.e., transgender-affirmative care or trans-affirmative care), in specific. In response to the acknowledgment of such a gap, research has been in development regarding the impact health care training curriculum has on healthcare workers’ and trainees’ attitudes toward and knowledge of transgender patients. For example, recent research has developed and piloted different training curricula, tested multiple ways to deliver the content (e.g., didactics, multi-part trainings, panel discussions), and included various audiences (e.g., medical and nursing students, OB-GYN
and family medicine residents, and mental health professionals; Austin & Craig, 2015; Braun, Garcia-Grossman, Quiñones-Rivera, & Deutsch, 2017; Bukowski, Haymer, & Sridhar, 2017; Click et al., 2019; Dubin et al., 2018; Klotzbaugh, Ballout, & Spencer, 2019; Stroumsa, Shires, Richardson, Jaffee, & Woodford, 2019). Indeed, these studies have found that an increase in transgender-specific health care training curriculum often results in several important outcomes: 1) awareness of transgender patients’ ongoing experiences of stigmatization, prejudice, and discrimination; 2) knowledge of affirmative care practices; and 3) improvement in attitudes toward the transgender community. Despite these important findings, it remains inconclusive regarding what the health care training curriculum should entail, who the training should be targeted toward, and how the training should be delivered. Critically, these trainings have at times been specific in their curricular scope (e.g., discussing specific medication dosing but excluding an introduction to accurate pronouns), limited in being accessible by the entire health care team (e.g., targeting generalist medical practitioners but excluding medical assistants), and/or delivered from one perspective (e.g., not integrating perspectives from the professional and patient).

What has been consistent throughout time is that contact as an intervention (i.e., personal contact, contact with educational materials, and/or contact with general media outlets) has been found to be associated with improved attitudes toward and knowledge of marginalized communities (Austin & Craig, 2015; Braun et al., 2017; Bukowski et al., 2017; Case & Stewart, 2013; Claman, 2009; Click et al., 2019; Dubin et al., 2018; Frazier, 1949; King, Winter, & Webster, 2009; Klotzbaugh et al., 2019; Norton & Herek, 2013; Reed, 2018; Stroumsa et al., 2019; Tee & Hegarty, 2006; Tompkins, Shields, Hillman, & White, 2015; West, Hewstone, & Lolliot, 2014; Willoughby et al., 2011; Yuker & Hurley, 1987). Accordingly, the current study
explored the impact contact with a transgender-affirmative care training may have on healthcare workers’ and trainees’ attitudes toward and knowledge of routine care and transition support for transgender individuals. The study’s aims were to contribute to the existing health care curricula by: 1) developing content that is easily consumable, evidence-based, and addresses basic transgender terminology, barriers to care transgender individuals currently (and historically) face, and affirmative approaches to routine care and transition support; 2) inviting all healthcare workers and trainees in a given setting that impact the experience of a transgender patient to attend; and 3) integrating the aforementioned forms of contact (i.e., self-disclosure, educational content, and general media references) to further target attitudes. These aims could provoke the subsequent development of field-specific or institution-wide mandatory trans-affirmative care trainings as potential prejudice-reduction interventions to improve the approach to care, and, in turn, the health and well-being of the transgender community.

**Background**

**Defining Transgender Identities**

*Sex* is defined as biological and physiological characteristics, such as internal and external genitalia, chromosomal makeup, and hormonal composition, that have historically been used to categorize people into groups of men, women, and intersex individuals (Belluardo-Crosby & Lillis, 2012; Trans Student Educational Resources (TSER), 2011). *Sex* is the category that is typically assigned at birth, and often how an infant is socialized. *Gender* is operationalized as the socially constructed roles, behaviors, activities, and attributes that a society relates to social norms; categories include masculinity, femininity, men, women, intersex, and gender non-conforming individuals (e.g., non-binary, genderqueer, genderfluid, etc.; Belluardo-Crosby & Lillis, 2012; TSER, 2011), among others. Notably, the terms used to
describe gender identity are consistently in a state of development, and often are dependent on an individual’s preference; therefore, the terms used in this document are not comprehensive. Each individual has a unique gender identity, or their sense of being male, female, other gender(s), or a combination of genders, and a unique gender expression, or how they manifest their gender through clothing, hairstyle, mannerisms, etc. (TSER, 2011). It is critical to acknowledge that sex and gender differ, with one based upon biology and one based upon self-identification (respectively), despite them at times being used interchangeably. In addition, sexuality, a category distinct from sex and gender that deserves unique attention, refers to an individual’s sexual orientation identity, sexual behavior, and sexual attraction (TSER, 2011). All of these terms come together to uniquely describe an individual, but importantly, individuals can only accurately identify and describe themselves.

A frequently cited definition by Stryker (1994) considers the meaning of transgender to be, “an umbrella term that refers to all identities or practices that cross over, cut across, move between, or otherwise queer socially constructed sex/gender boundaries” (p. 251). In other words, transgender individuals are conventionally recognized as those whose gender identity or expression differs from the sex they were assigned at birth (Hughto et al., 2015; King et al., 2009; Norton & Herek, 2013; Tebbe, Moradi, & Ege, 2014). The term transgender is not necessarily indicative of a specific type of gender expression, sexual orientation, hormonal makeup, physical anatomy, or other characteristics (TSER, 2011). Some transgender individuals may pursue a transition to move toward aligning their gender expression, gender identity, and/or sex assigned at birth. At times this occurs within the gender binary (e.g., female-to-male or male-to-female), but at other times, the transition may exist outside of the binary. Transitioning could be in the form of coming out to family and friends, changing legal documents (e.g., name,
gender marker), pursuing hormonal and/or surgical interventions, or a combination of these listed; however, this is not an extensive list. Importantly, some individuals who identify as transgender may not choose to transition for a multitude of reasons. The term *transsexual* has historically been used to separate transgender individuals who desire to pursue a physical transition from those who do not, and although this term is arguably outdated, it is still used occasionally in the current psychological and medical literature, as well as by individuals who self-identify as transsexual (TSER, 2011). The health care needs of transgender individuals, whether they need routine care, transition support, or both, will be discussed in detail in a later section. Given the breadth of the term transgender, estimates of the transgender community have ranged from 0.03% to 0.05% of the United States population (Gates, 2011; Hughto et al., 2015), to 3% to 5% (Hughto et al., 2015), and in some studies, have been found to be as much as 8% to 10% (Grant et al., 2011; James et al., 2016; Tebbe & Moradi, 2012). The rationale behind the discrepancy between population size estimates of the transgender community is multifaceted. The majority of the data on the size of the transgender population has originated from reports from medical, psychiatric, and psychological care professionals. These data may be skewed, since not all transgender individuals seek services from those providers, and not all transgender individuals seeking services are out to their providers (Tebbe & Moradi, 2012). Furthermore, because many transgender individuals prefer to identify in ways that may not reflect their transgender identities (e.g., someone may identify as a woman, rather than a transwoman), and not all surveys or studies ask about sex assigned at birth and current gender identification (i.e., the two-step method), it can be difficult to estimate the percentage of the population with identities that fall under the transgender umbrella. Nonetheless, the transgender population, large or small, has long been demanding healthcare workers’ and trainees’ attention regarding
understanding best practices to address routine- and transition-related health care needs. Lastly, the term *cisgender* is often used in sexual/gender minority literature to describe those whose gender identity and expression correspond with their sex assigned at birth (Tebbe et al., 2014).

**Defining Healthcare Workers**

The term *healthcare worker* covers a broad range of professionals who provide a unique variation of care for individuals. Healthcare is generally defined as the maintenance and restoration of physical, mental, and/or emotional health by the treatment and prevention of disease by trained and licensed professionals (e.g., medical, dentistry, clinical psychology, and public health; health care, 2019). Furthermore, the World Health Organization (2010) published a report titled, “International Classification of Health Workers,” thus classifying healthcare workers into five broad groupings: health professionals, health associate professionals, personal care workers in health services, health management and support personnel, and other health service providers not elsewhere classified. Given this definition, healthcare workers include, but are not limited to: psychologists, generalist medical practitioners, nursing professionals, dentists, paramedical practitioners, pharmacists, physiotherapists, dieticians and nutritionists, audiologists and speech therapists, healthcare trainees, technicians, medical assistants, chaplains, health service managers, medical secretaries, and clerical support workers.

It is inevitable that a transgender individual will encounter some version of a healthcare worker at some point in their life, therefore it is essential that all types of healthcare workers are educated on how to provide transgender-affirmative care. Furthermore, often times healthcare workers work alongside one another and are housed in the same care facility, so the current study welcomes any variation of healthcare workers to participate, as to not exclude anyone from the transgender-affirmative care trainings that will be delivered at different sites. As a result,
throughout the remainder of this manuscript, the term “healthcare worker” will be used to represent all physical health, mental health, healthcare trainees, and care support professionals, as introduced above (see the WHO’s 2010 report for a comprehensive listing of healthcare workers).

**Historical Pathologization of Transgender Identities by Health Care Institutions**

A substantial body of literature suggests that transgender individuals have encountered negative experiences when seeking health care services for decades (see *Gender Dysphoria and Disorders of Sex Development: Progress in Care and Knowledge* for a great overview; Kreukels, Steensma, & de Vries, 2014). These negative experiences are likely, in part, a product of the historical pathologization of transgender identities by health care institutions. Throughout time, the documentation and classification of mental and physical disorders and diseases has influenced the understanding of, and approach to treatment for, transgender individuals. The systemic movement by health care institutions to understand and affirm transgender identities is evident in the evolution of both the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the World Health Organization’s (WHO) *International Statistical Classification of Diseases and Related Health Problems* (ICD), which will be discussed in detail below.

**Historical Diagnoses**

Psychological and medical processes of developing language to reflect transgender identities, as well as understanding transgender individuals’ experiences, largely began in the nineteenth century; however, the existence of transgender identities long predates this effort (e.g., Native American Two-Spirit, Samoan Fa’afafine, Indian Hijra; Stryker, 2017). The labels and descriptions of transgender identities have varied throughout the years, paralleling the extent
to which researchers and healthcare workers have increasingly recognized the growing need for physical and mental health interventions for transgender individuals. In the late 1800s, Richard von Krafft-Ebing was recognized as the “leading scientific authority on sexuality,” and was often consulted on questions regarding sexual orientation and gender identity (Stryker, 2017, pg. 53). Krafft-Ebing published a medical compendium entitled *Psychopathia Sexualis* in 1886, which introduced several evolving terms that approximate our modern conceptualization of transgender identities. This unique document could be considered one of the earliest versions of a diagnostic manual that recognized transgender identities; however, many of the terms he coined would, today, be considered pathological and non-affirmative (Stryker, 2017). For example, several of Krafft-Ebing’s terms include: *antipathic sexual instinct*, translated to mean, “disliking what one should find erotic based on one’s sex or gender;” *eviration*, translated to mean, “a deep change of character in which a male’s feeling and inclinations become those of a woman;” *defemination*, translated to mean, “a deep change of character in which a female’s feelings and inclinations become those of a man;” and *metamorphosis sexualis paranoia*, translated to mean, “the psychotic delusion that one’s body was transforming into another sex” (Stryker, 2017, pg. 53-54). The terms that Krafft-Ebing coined appear to conflate sexual and gender identities, which we now know to be two separate entities. One example highlighting this conflation is Krafft-Ebing’s assertion that *mujerados* (i.e., “male women” as described by the Spanish conquistadors during the colonization of the Americas) had become feminized as a result of excessive masturbation that lead to the atrophy of their penis and testicles (Stryker, 2017). Furthermore, the specific language he used (e.g., *sexualis*) and the statements he made (e.g., “psychotic delusion”) insinuated that individuals who had thoughts or feelings of a sex different than the one they were assigned at birth were pathological. Krafft-Ebing’s influence on the medical and
psychological literature highlights the longstanding confusion of the separation between sexual and gender identities, which has frequently been perpetuated in modern health care settings. However, there were other early healthcare workers that more closely approximated our modern understanding of transgender identities, such as psychiatrist Max Marcuse in 1913 describing *Geschlechtsumwandlungstreib*, translated to mean, “drive for sex transformation,” and in the same year psychologist Havelock Ellis describing *sexo-aesthetic inversion*, translated to mean, “wanting to look like the other sex” (Stryker, 2017, pg. 54). Magnus Hirschfeld was an additional early advocate that coined the term *transvestite* in the early twentieth century that has persisted into our modern transgender terminology (Drescher, 2014; Stryker, 2017). Hirschfeld is frequently credited to be the first to distinguish the difference between “desires of homosexuality (to have partners of the same sex) from those of transsexualism (to live as the other sex)” (Drescher, 2014, pg. 139). Despite Hirschfeld’s important contribution to the transgender literature, he, too, used language that lacked distinction of gender identity from sexuality. For example, he developed the concept of *sexual intermediaries*, proposing that variations in sexuality and gender, such as sex characteristics, secondary sex traits, sexual preferences, psychological inclinations, and culturally acquired habits and practices, were rooted in biology (Stryker, 2017). Although Hirschfeld is often cited as a pivotal figure in the historical advocacy for transgender individuals, his descriptive language choices likely had an impact on the mid-twentieth century’s classification of transgender identities into psychological and medical texts. Critically, these early pioneers were the first major advocates for transgender-affirmative health care, and generated further discussion and innovation throughout the subsequent decades.
**Modernized Diagnoses**

As time progressed and more formal manuals were developed to categorize psychological disorders and medical diseases, the increasingly modern concept of transgender identities was slowly introduced. It was not until the second version of the DSM that the concept of gender identity was introduced (APA, 1968). In this version, transgender identities were listed under the category of Sexual Deviation and labeled as “Transsexualism.” Concurrently, the medicalization manual, the ICD, classified these identities as “Transvestitism” in its eighth edition in 1965 (WHO, 1965). Although the term *transvestite* is currently recognized as a person who derives sexual pleasure from dressing in clothes of the opposite sex, it has been argued that the term *transvestitism* in the ICD-8 (at times alternatively spelled “transvestism”) was originally used synonymously for *transsexualism* (i.e., portraying the historical conflation of sexuality and gender identity; Drescher, 2014). There is some ambiguity regarding these terms, especially given that definitions of diagnostic categories were not provided until the ICD-9 was released (Drescher, 2014). However, there is evidence that surgeons in the mid-twentieth century were using the term transvestite, as introduced by Hirschfeld, when referring to transgender patients undergoing a physical transition prior to the introduction of a formal ICD diagnosis (Hamburger, Sturup, & Dahl-Iversen, 1953). It is critical to question why there was a delay in adding these identities to either of these manuals, given the early conceptualizations of them by Krafft-Ebing (1886), and early documented transition-related surgeries performed on transgender individuals (Hamburger et al., 1953). Perhaps the lack of inclusion of these identities in early editions of diagnostic manuals is a product of the high amounts of stigma during the mid-1900s, which reflects the social attitude of preventing transgender individuals from receiving formal psychological and physical assessments that many surgeons required before they would provide
their services to help facilitate physical transitions. However, although the existence of transgender identities in either the DSM or ICD inherently pathologizes them, it has arguably been considered a step forward in a positive direction because those documents insinuate that conditions can be “cured” or addressed by external interventions. Problematically, as will be discussed further on, the historical treatment approaches were far from affirmative toward transgender individuals; rather, they were focused on eliminating the thoughts and/or feelings of being transgender (i.e., focused on enforcing the gender binary and discouraging transitioning).

In monitoring the development of both manuals, the conceptualization of transgender identities experienced many shifts, which in turn affected the attitude that healthcare workers held toward transgender individuals and the type of health care interventions they utilized. As mentioned, the ICD-8 was the first manual to recognize transgender identities in 1965 with the parent category of “Sexual Deviations” and the diagnosis label of “Transvestitism.” Shortly following in 1968, the DSM-II introduced transgender identities in the parent category of disorders of “Sexual Deviations,” with the diagnostic label of “Transsexualism,” whereas both manuals mirrored the long-standing conceptualization Krafft-Ebing proposed in the late 1800s. Over time, the parent category and the diagnostic label experienced a shift in language in both manuals. In 1975, the ICD-9 maintained the parent category of “Sexual Deviations,” but changed and expanded the diagnostic labels to include “Transvestism” and “Trans-sexualism” (sic). During this period, the WHO began to provide definitions of diagnostic categories, and defined transvestism as, “Sexual deviation in which sexual pleasure is derived from dressing in clothes of the opposite sex. There is no consistent attempt to take on the identity or behaviour of the opposite sex” (Drescher, 2014, pg. 142). Although both of these diagnostic labels were under the sexual deviations parent category, there was an important shift in differentiating trans-
sexualism (sic) as a separate and exclusionary diagnosis, with a new emphasis on gender identity (as was the case for the DSM-II; Drescher, 2014). This shift in the ICD-9 likely signifies the attempt to accommodate a growing body of literature regarding clinical presentations and treatment of transgender individuals, and it perhaps also provides insight as to why transvestitism and transvestism were earlier used synonymously with transsexualism.

In 1980, the DSM-III changed their parent category to “Psychosexual Disorders,” and expanded the diagnostic labels to additionally include “Gender Identity Disorder of Childhood.” This was the first time a manual explicitly acknowledged gender identity, but was still arguably intermingling the differential expressions of sexuality and gender identity. Furthermore, it was the first time a manual explicitly addressed gender identity development in non-adults. In 1987, the DSM-III-R changed the parent category to “Disorders Usually First Evident in Infancy, Childhood, or Adolescence,” and expanded the diagnostic labels to additionally include “Gender Identity Disorder of Adolescence and Adulthood, Nontranssexual Type.” This was an important change, as it began the movement forward in recognizing that identifying as transgender is a separate experience from identifying as a sexual minority. In 1990, the ICD-10 changed the parent category to “Gender Identity Disorders,” and changed the diagnostic labels to “Transsexualism,” “Dual-Role Transvestism,” “Gender Identity Disorder of Childhood,” “Other Gender Identity Disorder,” and/or “Gender Identity Disorder, Unspecified.” In 1994, the task force of the DSM-IV changed the parent category to “Sexual and Gender Identity Disorders,” and changed the diagnostic labels to “Gender Identity Disorders in Adolescents or Adults” or “Gender Identity Disorders in Children.” This change was maintained in the DSM-IV-TR, which was published in 2000. However, when the DSM-5 was published in 2013, there was a major change to the parent category, which is now labeled as “Gender Dysphoria,” and the
diagnostic labels changed to “Gender Dysphoria in Adolescents or Adults” or “Gender Dysphoria in Children.” This shift in language continued to overtly acknowledge the distinct differences between sexual and gender identities and began to sway from Krafft-Ebing’s (1886) original conceptualizations and more toward Magnus Hirschfeld’s (1923) ideas of gender and sexuality being distinctly different. Several years later in 2018, the ICD-11 made a major change to the parent category, too, which is now labeled as “Gender Incongruence,” and the diagnostic labels changed to “Gender Incongruence of Adolescence and Adulthood” or “Gender Incongruence of Childhood.”

The parallel, yet staggered development of both manuals illustrates the historically strong separation of medical and psychological services and reflects the lack of consensus on how to appropriately address and work with transgender individuals. What is striking is that the ICD was the first to conceptualize transgender identities in 1965, three years prior to it being introduced in the DSM, despite it being the common trajectory for a transgender individual to go through the mental health realm before being seen by a medical professional (i.e., medical professionals often required a diagnosis and letter from a mental health professional before providing medical services; Budge, 2015; Coleman et al. 2012; Cochran, Reed, & Gleason, 2016; Grant et al., 2011; James et al., 2016). The lack of consistency regarding appropriate diagnostic labels across health care institutions represents the scarcity of uniformly practiced transgender-affirmative care, as diagnostic labels and criteria often guide decision making and approach to treatment. Of course, though, as the categorization and diagnosis shifted, the way healthcare workers conceptualized transgender identities shifted as well, eventually leading to the development of more affirmative practices.
**Historical Treatment**

Although the presence of transgender individuals has been documented throughout human history (see *Transgender History: The Roots of Today’s Revolution* for an excellent overview; Stryker, 2017), the mainstream awareness of the transgender community and the development of health care interventions did not blossom until roughly the twentieth century, paralleling the introduction of transgender identities to both the medical and psychological diagnostic manuals, as previously discussed. However, the original psychological and medical treatment approaches for transgender individuals was not always affirmative and person-centered.

**Historical Psychological Treatment.** The psychological treatment of transgender individuals was historically rooted within conversion therapy practices (Wright, Candy, & King, 2018). A recent systematic review of conversion therapy and access to transition-related care found that a majority of conversion therapies were largely guided by psychoanalysis and open-ended play psychotherapy to suppress or divert an individual from affirming their authentic gender identity, henceforth pushing them to conform to a cisgender identity (Wright et al., 2018). These clinical interventions were focused on making an individual’s behavior, dress, and mannerisms more consistent and stereotypical of their sex assigned at birth (Substance Abuse and Mental Health Services Administration (SAMHSA), 2015). Consumers of conversion therapy at times sought services on their own free will, but many were involuntarily enrolled as a result of pressures from family members, religious figures, cultural and/or social expectations, as well as their own internal struggles (Fetner, 2005; Robinson & Spivey, 2007; Shidlo & Schroeder, 2002; Stewart, 2008; Wright et al., 2018). Most commonly, requests for conversion therapy have been found to come from a parent or guardian, which are typically driven by
misinformation and negative social attitudes and/or discriminatory actions directed toward their family (SAMHSA, 2015). Problematically, the requests for conversion therapy have historically been rooted in fear, whereas many mental health clinicians receive requests to not only change an actual gender identity, but also perceived or future gender expressions or identities (i.e., if a parent suspects that their child may identify as transgender, they may seek out conversion therapy despite the child ever disclosing of a gender identity different from the sex they were assigned at birth; SAMHSA, 2015). A growing body of research has asserted that conversion therapy can cause psychological damage to the individual, be oppressive by nature, ineffective at successfully “converting” an individual, and ill-informed on the cultural shift toward acknowledging the variability of gender identification (Fetner, 2005; Robinson & Spivey, 2007; Shidlo & Schroeder, 2002; Stewart, 2008; Wright et al., 2018). In 2015, SAMHSA published a report titled, “Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth,” as a collaborative effort between experts in the field examining existing research, professional health association reports and summaries, and expert clinical guidelines regarding best practices for lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals. The team of experts asserted that there is no methodologically sound research demonstrating the effectiveness of conversion therapy, and concluded:

“Given the lack of evidence of efficacy and the potential risk of serious harm, every major medical, psychiatric, psychological, and professional mental health organization, including the American Psychological Association, the American Psychiatric Association, the National Association for Social Work, the Pan American Health Organization, and the American Academy of Child and Adolescent Psychiatry, has taken
measures to end conversion therapy efforts to change sexual orientation” (SAMHSA, 2015, p. 25).

It is noteworthy, however, to acknowledge that SAMHSA’s (2015) overarching conclusion did not explicitly include language regarding efforts to end conversion therapy efforts to change sexual orientation and gender identity. SAMHSA (2015) stated that conclusions regarding conversion therapy with gender minority individuals are “complicated” given that there currently remains a psychiatric diagnosis of Gender Dysphoria (compared to the removal of Homosexuality from the DSM-III in 1983). Despite this complication, there are several pieces of evidence in the current literature asserting that conversion therapy practices for gender minority individuals are equally as harmful: 1) there is no peer-reviewed research demonstrating the efficacy of conversion therapy for gender minority individuals (SAMHSA, 2015; Wright et al., 2018); 2) there are clear ethical concerns of conversion therapy practices (Coleman et al., 2012); 3) there are studies indicating that conversion therapy is harmful for other populations (e.g., sexual minorities; Fetner, 2005; Robinson & Spivey, 2007; Shidlo & Schroeder, 2002; Stewart, 2008; Wright et al., 2018); and 4) there is evidence that gender dysphoria is unlikely to remit without affirmative social and/or medical interventions (SAMHSA, 2015; Grant et al., 2011; James et al., 2015). Based upon expert consensus after a thorough overview of the literature regarding conversion therapy practices for gender minority individuals, the team of experts stated:

“In conclusion, given the lack of evidence for the efficacy [of] conversion therapy and the fact that conversion therapy efforts are based on a view of gender diversity that runs counter to scientific consensus, in addition to evidence that rejecting behaviors and a lack of support have adverse effects on the psychological well-being of gender minority youth
– conversion therapy, as well as any therapeutic intervention with an a priori goal for a child’s or adolescent’s gender expression, gender identity, or sexual orientation, is inappropriate” (SAMHSA, 2015, pg. 26).

Despite extensive documentation reporting the damage that can come from conversion therapy, this approach to treatment has persisted throughout time and is still practiced in some clinics today (Grant et al., 2011; James et al., 2016). James and colleagues (2016) administered a recent survey and found that some mental health clinicians practice conversion therapy despite clear statements from the APA and other mental health organizations articulating that it has been proven ineffective, harmful, coercive, and abusive toward transgender individuals (SAMHSA 2015; Wright et al., 2018). In their survey, they found that upwards of 13% of their respondents reported that their mental health clinician tried to stop them from transitioning or even claiming a transgender identity. Of those who experienced lack of support from their clinician, 8% reported “de-transitioning” temporarily or permanently at some point (e.g., they went back to living as their sex assigned at birth). Interestingly, though, 62% of those who de-transitioned only did so temporarily, and over time resumed living full time in the gender with which they identify (i.e., supporting the notion that gender dysphoria is unlikely to remit without appropriate affirmative supports). In fact, those who did de-transition cited several reasons that influenced their decision to do so, such as facing too much harassment or discrimination after they began transitioning (31%), having trouble getting a job (29%), or pressure from a parent (36%), spouse (18%), or other family members (26%). Not surprisingly, the medical treatment of transgender individuals originated from a hetero- and cis-normative standpoint that often, too, led to severe psychological and social suffering.
**Historical Medical Treatment.** Although there is evidence of transgender individuals transitioning in ancient civilizations, the medical treatment of transgender individuals was not *readily* accessible until the early twentieth century. Magnus Hirschfeld not only had a major influence on transgender terminology development, but he published one of the first transgender health care treatment texts in 1910 titled *The Transvestites*, and in 1919, he established the Institute for Sexual Science in Berlin (note: terminology had not yet evolved to where it is today; Stryker, 2017). Hirschfeld was one of the first physicians to offer hormone replacement therapy, surgeries, or both for transgender patients. At the Institute for Sexual Science, not only did he offer affirmative services for transgender patients, but he also actively hired transgender-identified staff to further understand their experiences. Between 1922 and 1931, Hirschfeld performed several surgeries on one of his employees, Dorchen Richter, which has been considered to be one of the first male-to-female transition surgeries on record in the modern medical context. In 1930, he subsequently helped aid in arranging the medical care for another transwoman, Lilli Elbe, who unfortunately died in 1931 due to infection-related complications from surgery (Naz Khan, 2016). Unfortunately, a great deal of Hirschfeld’s work was lost during the Nazi book burnings in 1933, along with his institute being destructed, leading to minimal advancements in transgender health care for a period of time.

In America, Alfred Kinsey founded the Institute for Sex Research at Indiana University in 1947 (currently known as the Kinsey Institute). Kinsey is noted to be one of the first to use the term “transsexual” in his gender studies, making him an influential proponent in the American approach to health care for transgender individuals. Shortly following, in 1952, Christine Jorgensen was the first documented American transwoman to pursue surgery (Naz Khan, 2016; Stryker, 2017). However, the health care in America was not advanced with regard
to such surgeries at the time, leading her to travel to Denmark to receive surgery from Christian Hamburger (Hamburger et al., 1953). Jorgensen’s case was widely publicized through the *New York Times*, causing an influx of requests for surgery with Hamburger by American transgender individuals (Hamburger et al., 1953; Naz Khan, 2016). Hamburger advocated for transgender patients to receive care locally, and often referred patients to endocrinologist Harry Benjamin, who studied alongside Hirschfeld in Berlin, later relocating to America and establishing offices in New York and California (Naz Khan, 2016). Benjamin is recognized as one of the leading influential figures on modern American transgender health care, especially following the publication of his book *The Transsexual Phenomenon* in 1966. This book suggested hormone replacement therapy and surgery to be the best approach to care for transgender patients seeking such a transition – not solely psychotherapy, and certainly not conversion therapy. Notably, Hirschfeld, Kinsey, Hamburger, and Benjamin’s progressive approaches to care for transgender individuals were in stark contrast to the mental health treatment of their time, which, as discussed, was largely focused on preventing transgender individuals from expressing their true gender identity via conversion therapy practices. These leading figures paved a pathway for the advocacy of, and approach to care for, transgender individuals across the world.

With the support of Benjamin’s publication, America’s first Gender Identity Clinic opened at Johns Hopkins in 1966 with the original treatment team comprised of Milton Edgerton (Chief of Plastic Surgery until 1970), Johns Hoopes (Chief of Plastic Surgery after 1970), John Money (Psychologist), and Claude Migeon (Endocrinologist; Siotos et al., 2018). As reviewed by Siotos and colleagues (2018), for transgender patients who were seeking transition-related services at Johns Hopkins, they were required to complete specific tasks over the course of four phases. The first phase required prospective patients to submit an application that contained
extensive medical, surgical, and social history, their birth certificate, and any police records. The clinic also required documentation of family support, general mental health support by a psychiatrist in the community, and a preliminary psychiatric evaluation as a prerequisite for eligibility. Following, prospective patients were invited for a full evaluation, including an interview with the patient and their family members, a psychiatric and psychological evaluation, an encephalogram, IQ testing, an evaluation by a social worker, and a physical and genetic examination. If the prospective patient met eligibility criteria, physicians would initiate hormone replacement therapy. During the second phase, the now-admitted patients were required to live in the gender that they identify as from anywhere between six months to one year to become eligible for surgical interventions. In the third phase, patients would receive relevant surgical treatments and were provided immediate post-operative care. Lastly, in phase four, patients would periodically return to the clinic for annual physical examinations, interviews, and would complete questionnaires regarding their quality of life. Siotos and colleagues’ (2018) record review revealed that nearly 1,200 applications had been received by 1972. However, only seven transwomen and sixteen transmen received surgery, and the details regarding the substantially low percentage of surgical patients (relative to applicants) are unclear.

However, in 1976, researchers at Johns Hopkins questioned the necessity of medical interventions, stating in a controversial report titled “Sex Reassignment. Follow-up,” that transgender patients who received surgery did not presumably have an objective advantage in terms of “social rehabilitation” compared to who had not had surgery (i.e., there were no significant differences among participants; Meyer & Reter, 1979; Nutt, 2017; Siotos et al., 2018). The results of this report were based upon retrospective accounts from patients who originally applied for surgical services at Johns Hopkins Gender Identity Clinic: 15 who received surgery,
25 who had not received surgery, and 14 who had gone to another clinic for surgery (Brody, 1979; Meyer & Reter, 1979; Nutt, 2017; Siotos et al., 2018). These participants were asked to respond to questions regarding their adjustment following their social and/or physical transition, such as job and income status, residential stability, legal and psychiatric difficulties, and marital status, which the authors considered to be objective measures (Brody, 1979; Meyer & Reter, 1979). One of the researchers, Jon Meyer, was a fellow psychiatrist at Johns Hopkins and was interested in evaluating the difference in quality of life among transgender patients who received surgery versus those who had not (Siotos et al., 2018). Meyer has been documented to have expressed that he thinks only psychotherapy could be “curative,” and that surgery was only “subjectively satisfying” (Nutt, 2017; Siotos et al., 2018). An article in the New York Times quoted Meyer: “My personal feeling is that surgery is not a proper treatment for a psychiatric disorder, and it's clear to me that these patients have severe psychological problems that don't go away following surgery” (Brody, 1979, p. C1).

Following this publication, Johns Hopkins’ Chief of Psychiatry, Paul McHugh, decided to shut the clinic down, stating that “…Hopkins was fundamentally cooperating with a mental illness,” asserting that treatment for transgender patients should be psychiatric rather than surgical (Nutt, 2017, p. 1). The closure of this clinic was unprecedented, and the factors leading to its closure have been argued to be more nuanced than the outcome report published by Meyer and Reter (1979). Siotos and colleagues (2018) were granted access to the Archives of the Johns Hopkins Medical Institutions, and revealed additional factors that may have led to the closure of the clinic, including: 1) lack of stable funding of the clinic; 2) administrative staff and physicians not receiving reimbursement for their time spent in the clinic; 3) the constant flux of administrative staff and physicians leaving and being hired at Johns Hopkins; 4) lack of
communication within the clinic; 5) difficulty finding patients with substantial financial
resources to afford surgery (insurance was not typically reimbursing these surgeries at the time);
6) surgical techniques being relatively crude in America in the 1970s, often resulting in high
complication rates and poor function and/or appearance; and 7) there was a limited sample size
of patients that Meyer and Reter were basing their results off of; and 8) the survey development
and validation was described as “relatively rudimentary.” As a result of Johns Hopkins and other
academic hospitals closing their doors, the stigma and negativity around surgical interventions
for transgender individuals increased, and the likelihood of insurance coverage or out-of-pocket
affordability for hormones and/or surgeries became sparse (Siotos et al., 2018). For example, it
was estimated that the overall cost of surgery (including surgical fees and hospitalization) at
Johns Hopkins would approximate $28,176 in 2019 (Official Data Foundation, 2019; Siotos et
al., 2018). Notably, though, Johns Hopkins did re-open a Gender and Sex Clinic 38 years later in
2017, issuing a letter titled “Johns Hopkins Medicine’s Commitment to the LGBT Community”
(Nutt, 2017).

Although several researchers attempted to challenge Meyer and Reter’s (1979)
methodology and interpretation of their results, there were a great deal of other academic
hospitals that followed suit by discontinuing medical services for transgender patients or
remaining hesitant to establish transgender-specific care (Nutt, 2017). In an attempt to respond
to the controversial research and subsequent closing of clinics geared toward providing specific
services for transgender patients, Harry Benjamin established the Harry Benjamin International
Gender Dysphoria Association (HBIGDA) in 1978, and published the first version of “Standards
of Care for Gender Identity Disorders” (SOC) in 1979 (Naz Khan, 2016; Devor, 2019). The
HBIGDA was created in order to promote communication among professionals involved in
transgender health and to provide a consistent framework regarding those helping to facilitate transition-related care for transgender individuals (Summary Information, 2019). Benjamin’s co-founding members were Paul A. Walker, Richard Green, Jack C. Berger, Donald R. Laub, Charles L. Reynolds Jr., Leo Wollman, and Jude Patton; past presidents of the association were Leah Schaefer (1991-1995), Alice Webb (1999) and Eli Coleman (1999-2003; Summary Information, 2019). In 2006, the HBIGDA was renamed The World Professional Association for Transgender Health (WPATH), with a shift toward removing the language of “disorder” and rather emphasizing the overall health and well-being of transgender individuals (Summary Information, 2019). In the same vein, they renamed the standards in 2011 to be titled “Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People.”

The continued aim of the WPATH SOC is to further standardize approaches to care and establish a more formalized outline of recommendations for the assessment and treatment of transgender individuals seeking social, hormonal, and/or surgical interventions (Devor, 2019), which was articulated in the seventh, and current version, of the SOC:

“The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments” (Coleman et al., 2012, p. 1).
The introduction of the WPATH SOC, indeed, initiated a significant shift in how healthcare workers approached care for transgender patients. Yet, despite steps toward standardizing affirmative approaches to care, significant barriers to care have persisted into modern health care practices.

**Persistent Barriers to Care for Transgender Individuals**

Following the publication of Meyer and Reter’s (1979) article and the closure of the Johns Hopkins Gender Identity Clinic, transgender individuals’ access to transition and/or routine-related care, particularly in America, became increasingly limited (Siotos et al., 2018). Indeed, the closure of such an influential and esteemed clinic caused fear within the health care community, such as Paul Walker of the University of Texas, Galveston’s Gender Identity Clinic stating that he, among others, predicted that more patients would either go to private doctors or go abroad for “precipitous and often inappropriate surgery” (Brody, 1979, p. C1).

Despite there being opposing retrospective research supporting the positive social, emotional, and psychological impacts and satisfactory outcomes of hormonal and surgical interventions (Coleman et al., 2012; Hamburger et al., 1953; Naz Khan, 2016; Pauly, 1981), many insurance companies increasingly refused to cover transgender related health care, and self-pay hospital rates at major academic centers became difficult to afford (Siotos et al., 2018). In addition, conclusions proposed by Meyer and Reter directly conflicted with other team members at Johns Hopkins, which entered into the public discourse via articles published in the *Washington Post* (Nutt, 2017) and the *New York Times* (Brody, 1979). The publicity of these competing beliefs has long impacted the professional development of best practices for transgender-affirmative care, but also invited lay opinion and comments to influence public perception, as well as the health care delivery for transgender individuals.
Since transgender individuals have a gender identity or expression that differs from their sex assigned at birth, they are often perceived as “challenging” the gender binary. Historically, this has caused fear, confusion, and hatred among many cisgender individuals, which has led to the frequently cited stigma, prejudice, and discrimination toward the transgender community (Dispenza et al., 2012; Hughto et al., 2015; Stotzer, 2009; Walch et al., 2012). This specific type of prejudice is referred to as “transphobia” or “anti-transgender prejudice,” and encompasses the pathologization, stigmatization, and delegitimization of transgender individuals (King et al., 2009; Meyer, 2003; Tebbe & Moradi, 2012). Critically, these attitudes have not only affected transgender individuals’ mental health (e.g., depression, anxiety, suicidal ideation, attempts, and completions), but they have also created a culture of fear and hesitation among healthcare workers to take an affirmative approach when working with transgender individuals.

The frequent negative encounters and the hesitation to engage with healthcare workers supports the Minority Stress Theory, which was originally applied in the context of sexual minorities, but was later generalized to all sexual and gender minorities (Meyer, 2003; Testa et al., 2015). Ilan Meyer’s original theory posits that members of sexual minority groups will, over time, experience chronic stress due to stigmatizing, prejudicial, and discriminatory encounters. This is theorized to contribute to a higher prevalence of mental, behavioral, and physical health issues within the sexual minority population. Meyer articulates several specific pathways in which sexual minority individuals may experience minority stress. One pathway includes distal (i.e., external) stressors, which involve direct experiences of discrimination, rejection, or violence related to one’s sexual minority identity. Another pathway includes proximal (i.e., internal) stressors, which include the fear and anticipation of further victimization or discrimination, the mistrust of others, the internalization of negative self-thoughts (i.e.,
“internalized homophobia”), and the stress regarding concealing one’s sexual minority identity. Conversely, Meyer also articulates several factors specific to sexual minority individuals that have the potential to mitigate minority stress. For example, if sexual minority individuals actively engage with the sexual minority community, they have a greater likelihood of accessing resilience factors, such as having social and emotional support from allies who have shared identities and experiences, and who express pride in their identity and community involvement.

The distal and proximal stressors articulated in Meyer’s original Minority Stress Theory have been generalized to describe the experience of gender minority individuals (Testa et al., 2015). Gender minority individuals, too, routinely experience prejudice, face rejection, feel the need to hide and/or conceal their identity, internalize negative statements made toward them, and need to exhibit coping mechanisms or resilience in response to these stressors. It is clearly documented that gender minority individuals routinely experience distal stressors, such as gender-related discrimination, rejection, victimization, and they lack consistent affirmation of their gender identity (Clements-Nolle et al., 2006; Grant et al., 2011; James et al., 2015; Kenagy, 2005; Marcellin, Scheim, Bauer, & Redman, 2013; Testa et al., 2015; Xavier et al., 2007). Furthermore, gender minority individuals, too, experience proximal stressors, such as feeling negative about their own identity and being associated with the transgender community (i.e., “internalized transphobia”), anticipating negative outcomes in multiple domains of life (e.g., employment (Reed, Franks, Scherr, 2015; Schilt, 2010), health care (Clements-Nolle et al., 2006; Grant et al., 2011; James et al., 2015; Kenagy, 2005; Marcellin, Scheim, Bauer, & Redman, 2013; Testa et al., 2015; Xavier et al., 2007), housing (Grant et al., 2011; James et al., 2016), personal relationships (Hughto et al., 2015; Testa et al., 2015), and access to resources (Hughto
et al., 2015), and face unique struggles to conceal one’s gender identity at different stages of one’s transition (Testa et al., 2015).

Minority stress is, of course, unique to sexual and gender minority populations and is maintained through the battle between upholding one’s self-identity (that often challenges societal norms) and not succumbing to the identity one is expected to present depending on social, cultural, and political pressures. Thus, due to living in fear and facing the competition of societal expectations and personal aspirations, transgender individuals may consider seeking health care services to help alleviate their distress through differential means (e.g., psychotherapy, hormone replacement therapy, gender confirmation surgery). The difficulty is that a majority of healthcare workers are not trained specifically on working with transgender individuals; thus, as a result, healthcare workers may consciously or unconsciously create an unwelcoming environment. An example of minority stressors that a transgender individual may encounter in a health care setting may be a mental health clinician assuming that the individual only wants to focus the clinical discussion on gender identity or a physician making inaccurate assumptions about the individual’s current anatomy. Austin and Craig (2015) succinctly summarized these arguments by stating, “As result of being consistently exposed to transphobic attitudes, beliefs, and behaviors, transgender individuals may develop negative patterns of thinking about themselves and their futures, which in turn may affect emotional and behavioral responses” (pg. 24). Therefore, despite transgender individuals desiring support from healthcare workers, they are likely to be reserved and cautious when disclosing personal information to certain healthcare workers, given their history.
Identifying Barriers

A strategic way to address minority stressors and reduce transgender individuals’ fear and hesitation to seek health care is to first become aware of the longstanding barriers to care for this population. The biggest barrier to adequate mental health support, safe hormone replacement therapy, and appropriate general medical and transition-related care for transgender patients is the lack of access to affirmative care (Brody, 1979; Clements-Nolle et al., 2006; Coleman et al., 2012; Grant et al., 2011; James et al., 2015; Kenagy, 2005; Marcellin et al., 2013; Testa et al., 2015; Xavier et al., 2007). Health care institutions undeniably have the infrastructure to support transgender patients (i.e., they have highly trained healthcare workers, population-based care models, and adequate tools to meet the needs of the transgender population); yet, the historical fear and misunderstanding of the transgender community has led healthcare workers and institutions to create unnecessary barriers to care for these individuals. This is supported by the fact that, following the closure of Johns Hopkins Gender Identity Clinic, there was a major setback in the successive establishment of transgender-affirmative care clinics in America, and many healthcare workers remained uncertain or skeptical about best care practices for the transgender population. Even healthcare workers known to support the transgender community, such as Walker (co-founder of the HBIGDA and head of an information and referral service for transgender patients at the University of Texas, Galveston) was quoted to have said:

“If [Meyer and Reter’s] study shows anything at all, it’s that careful screening before surgery is critical to the outcome. You have to be very careful about whom you operate on. Many applicants, certain that they want an operation, give a very convincing biography of a transsexual. They know exactly what to say. But if you put up any barriers to the surgery, they change their minds” (Brody, 1979).
Several other influential institutions (e.g., Brown University, Stanford University) agreed with Walker, requiring prospective transgender patients to pass a "real-life test" (RLT) by living in the gender that they identified with full time (i.e., 24/7) from anywhere between one to two years before they could receive surgery (Brody, 1979). Norman Fisk, a psychiatrist at Stanford University, asserted that patients had to be psychologically, socially, and economically stable living in the gender they identified as before surgeons would operate. Interestingly, the concept of the RLT was originally maintained through the sixth version of the WPATH SOC, specifying that a transgender individual must in some capacity (e.g., at work or school, in social realms, via name change) demonstrate that they are living full-time as the gender they identify with (Coleman et al., 2012). There was a significant shift in the seventh version, as there is no longer explicit language regarding specific parameters prescribed to a RLT; rather, the language suggests that an individual live in the gender that they identify with throughout their transition, but it is not required. Although these requirements presumably sought to better the lives of transgender individuals by ensuring a thorough and informed decision, they may have intentionally or unintentionally created additional barriers to accessing affirmative care. In other words, transgender individuals may not be able to fully fulfill the requirements outlined by health care institutions for several reasons, thus creating additional barriers. These reasons are multifaceted, including: psychological barriers (e.g., experiencing proximal and distal stressors; Meyer, 2003; Testa et al., 2015), socioeconomic barriers (e.g., transportation, housing, affording gender-affirming clothing), financial barriers (e.g., lack of insurance, lack of employment/income; Grant et al., 2011; James et al., 2016; Reed et al., 2015) and social barriers (e.g., stigma, prejudice, discrimination; Grant et al., 2011; James et al., 2016). In addition, it has been documented that transgender individuals have increasingly faced other barriers, including:
logistical barriers (e.g., traveling long distances from rural areas, finding a reputable transgender-affirmative clinic/professional, being denied care as a result of not meeting all requirements), internal barriers within health care systems (e.g., disorganized electronic health records (EHRs), inappropriate intake forms, unnecessary referrals to labs or specialty care, non-accommodating clinic facilities), and historical experiences in health care settings (e.g., fear of being mistreated, stigmatized, and discriminated against by their healthcare worker, and having low confidence in healthcare workers’ ability; Clements-Nolle et al., 2006; Coleman et al., 2012; Grant et al., 2011; James et al., 2015; Kenagy, 2005; Marcellin et al., 2013; Testa et al., 2012; Xavier et al., 2007). These barriers listed are, of course, not necessarily novel for minority individuals, but present a unique, and at times, elevated challenge for transgender individuals in receiving appropriate care.

**Implications of Barriers**

Without appropriate routine- and transition-related care, transgender individuals become vulnerable to unnecessary mental and physical health challenges. With insufficient access to quality care and coverage, transgender individuals are, not surprisingly, at an elevated risk of mental and physical health disparities. The link between experiences of discrimination and marginalization and lack of access to care with poor physical and mental health outcomes have been well documented (Clements-Nolle et al., 2006; Coleman et al., 2012; Grant et al., 2011; Hughto et al., 2015; James et al., 2015; Kenagy, 2005; King et al., 2009; Marcellin et al., 2013; Testa et al., 2015; Xavier et al., 2007). Those who are persistently exposed to stigma and discrimination are more likely to report poor overall physical and mental health, and exhibit poor coping mechanisms, which is a clear trend within the transgender community.

**Data on implications of barriers.** The National Center for Transgender Equality (NCTE) has twice conducted the largest scale studies to-date that exclusively focus on capturing
the experiences of transgender individuals in the United States (Grant et al., 2011; James et al., 2016). The 2015 U.S. Transgender Survey collected responses from 27,715 individuals spanning all fifty states, the District of Columbia, American Samoa, Guam, Puerto Rico, and U.S. military bases overseas. This was NCTE’s follow-up study from the groundbreaking 2011 National Transgender Discrimination Survey that collected 6,400 responses exclusively from transgender identified individuals. The sample sizes from both the 2011 and 2015 surveys are notable, especially given that the previously mentioned estimates of the transgender community to be, on average, 5% of the United States population (Tebbe & Moradi, 2012). Given this general estimate, both surveys have served as substantial bases to thoroughly quantify the amount of prejudice, discrimination, and violence the transgender community has faced, as well as serve to evaluate the quality of care these individuals have historically received. These bases have either supported existing research or have prompted further research to understand the historical pathologization of transgender identities, and to investigate how it has permeated into the modern health care of transgender individuals.

Results from these surveys, along with similar lines of research, provide insight into the pervasive impact the barriers to care have had that have persisted into the modern treatment of transgender individuals. In the context of financial barriers, one quarter of transgender respondents reported facing barriers with their insurance companies. Examples of such troubles include: general lack of access to insurance; insurance companies refusing to change the name and/or gender on their policy; denying coverage for services considered to be sex-specific, including routine sexual or reproductive health screenings (e.g., pap smears, prostate exams, mammograms), “cosmetic,” or “experimental” (Dubin et al., 2018); denying coverage for other routine health care; and denying transition-related care (e.g., hormones, surgery). Lombardi and
colleagues (2002) reported similar findings, explaining that transgender individuals were over three times more likely than cisgender individuals to experience economic discrimination (e.g., being denied a job, being fired from a job). Furthermore, Reed and colleagues (2015) found that transgender individuals were perceived to be less socially and psychologically fit for prospective jobs when compared to equally qualified cisgender individuals. For those who were able to overcome financial barriers and see a healthcare worker, the experience of barriers to care did not dissipate. The 2015 U.S. Transgender Survey found that nearly all transgender respondents (87%) had seen a healthcare worker within the past year. Problematically, one-third (33%) of them encountered at least one negative experience related to their gender identity, including: having to teach their provider about appropriate care for transgender bodies; being asked invasive, unnecessary, or irrelevant questions in their visit; and being refused care specifically related to pursuing a physical transition. As a result of many healthcare workers’ lack of awareness, many transgender individuals report instances of mistreatment and stigma in health care settings, leading them to possibly postpone or even forgo necessary care (Belluardo-Crosby & Lillis, 2012; Cochran et al., 2017). For example, James and colleagues (2016) reported that nearly one-quarter (23%) of participants avoided treatment due to fear of experiencing mistreatment as a result of identifying as transgender. The experiences of mistreatment on the basis of gender identity, in and out of health care settings, have consistently been found over the years. In addition, Testa and colleagues (2012) found that 38% of transgender individuals from the Virginia Transgender Health Initiative Study (Xavier et al., 2007) reported a history of physical violence, and 26.6% reported a history of sexual violence. Similarly, Clements-Nolle and colleagues (2006) found that 36% of transgender individuals reported gender-related physical victimization, and 63% reported experiencing gender-related verbal victimization.
Indeed, the negative experiences in and out of health care realms have likely influenced transgender individuals’ tendency to postpone or forgo necessary care; thus, these historical and modern behaviors have likely had direct psychological, behavioral, and physical implications within the transgender community. For example, Grant and colleagues (2011) found that 26% of the transgender respondents reported using alcohol and drugs at some point in their life to cope with the impacts of discrimination. The usage of these substances, paired with lack of health care guidance on how to develop healthy coping mechanisms, may explain the increasing rates of severe health concerns within the transgender community. For example, it has been recorded that transgender individuals are at a substantially higher likelihood of living with HIV than the general population (Center for Disease Control, 2018; Grant et al., 2011; James et al., 2016). The 2015 U.S. Transgender Survey found that 1.4% of respondents were diagnosed with HIV (compared to 0.3% in the overall U.S. population). Furthermore, Bockting and colleagues (2013) reported that about a quarter (24.8%) of the transgender respondents had problems getting health care services, and subsections of their sample specifically had problems getting HIV prevention services and/or substance abuse treatment services. Transgender individuals are increasingly vulnerable when multiple minority identities intersect, such as being a transgender woman of color (Ahmed & Jindasurat, 2014; Bockting et al., 2013; Grant et al., 2011; James et al., 2016). This was illustrated in Grant and colleagues’ 2011 survey, whereas transgender individuals of color exhibited much higher rates of HIV than the general population (24.90% of African-Americans, 10.92% of Latino(a)s, 7.04% of American Indians, and 3.70% of Asian-Americans). James and colleagues (2016) presented similar findings, reporting that nearly one in five (19.0%) Black transgender women were living with HIV, and American Indian (4.6%) and Latina (4.4%) transgender women were more than three times as likely to be living with HIV.
compared to the overall transgender sample. Furthermore, the U.S. National Coalition of Anti-Violence Programs reported that, of 18 anti-LGBT or HIV-related homicides in 2013, nearly three-quarters (72%) of the victims were transgender women, and one-third (67%) were transgender women of color (Ahmed & Jindasurat, 2014).

Transgender individuals also reported a significant amount of serious psychological distress, amounting to nearly eight times the rate in the U.S. population (39% compared to 5%; James et al., 2016). The documented increased rates of psychological distress are reflected in the alarmingly high rates regarding thoughts of self-harm and/or suicide, suicide attempts, and suicide completion within the transgender community (Coleman et al., 2012; Grant et al., 2011; James et al., 2016; Hughto et al., 2015; Testa et al., 2012; Xavier et al., 2007). To illustrate, the 2015 U.S. Transgender Survey found that 82% of transgender respondents had serious thoughts about killing themselves at some point in their life, with nearly half (48%) of them having serious thoughts of suicide within the past year (relative to the survey dissemination; compared to 4% in the U.S. population). In addition, a striking 40% of transgender respondents had attempted suicide at some point in their lives (4.6% in the U.S. population), with nearly one-quarter (24%) having a plan to kill themselves within the past year (1.1% in the U.S. population), and 7% actively attempting suicide within the past year (0.6% in the U.S. population). Lastly, for those who had attempted suicide once or more in their lives, 34% cited that their earliest attempt was at the age of 13 or younger.

Data on health care seeking. Researchers have consistently found that transgender individuals have historically, and currently, seek therapy substantially more often than the majority of citizens in the United States. Grant and colleagues (2011) found that 75% of transgender individuals had sought psychotherapy either currently or in the past, and that an
additional 14% indicated that they intend to seek services in the future. This survey
demonstrated that an extremely high proportion of individuals who identify as transgender would
likely engage with a mental health clinician at some point in their lives. These numbers mirror a
brief survey that was created for a chapter titled “Providing a Welcoming Environment,” which
is a part of a book titled Adult Transgender Care: An Interdisciplinary Approach for Training
Mental Health Professionals. A brief survey conducted by the authors of this chapter indicated
that 84.4% of transgender individuals were either in treatment currently or had been in the past
(Cochran et al., 2016). James and colleagues (2016) found a similar statistic in their 2015
survey, reporting that 58% of transgender individuals had access to therapy, and that an
additional 19% desired therapy, but did not have access. Despite the slight variability of the
statistics across the years, they provide a stark contrast compared to the roughly 3% of people in
the United States who seek out psychological services (Budge, 2015; Grant et al., 2011). There
are several reasons that may lead transgender individuals into treatment, including general
psychological distress or transition-related reasons. As discussed in the historical overview
section, a mental health diagnosis (currently “Gender Dysphoria;” American Psychiatric
Association, 2013) by a mental health professional is typically required (although this varies
state by state) before a transgender individual can receive any sort of hormonal and/or surgical
intervention. This step reflects what is often called a “gatekeeper” role, meaning that many
mental health clinicians hold a great deal of authority, and at times can act as a major barrier
regarding the continuation (or not) of a medical transition that a transgender individual may
desire to pursue. Further, it illustrates the historical separation of healthcare workers/institutions,
and exemplifies the intentional or unintentional creation of unnecessary barriers that transgender
individuals undoubtedly encounter.
The separation within the health care field can often lead to frustration, delay in care seeking, or avoidance in seeking care on behalf of a transgender individual. For example, as briefly mentioned earlier, many transgender individuals often are required or highly recommended to visit with a mental health clinician prior to receiving any surgical and/or hormonal interventions from a medical professional. The current version of the WPATH SOC states, under the section discussing feminizing/masculinizing hormone therapy, that one letter is recommended to be written from a mental health professional (Coleman et al., 2012). However, the SOC states that, if a transgender individual is working with a multidisciplinary specialty team, an assessment and recommendation can be documented in their chart, and a letter may not be required. Given that not every healthcare worker works on an integrated team using shared medical records, there may be instances where a transgender individual initially goes to a general medical practitioner in a private practice, who then refers them to a mental health clinician for further assessment; thus, resulting in a barrier for that individual to pursue their transition due to the separation of the professionals. Furthermore, the SOC recommends one letter from a mental health profession for breast/chest surgery, and an additional letter from another mental health professional who provides an independent assessment for genital surgery. This, too, requires the coordination of care between physical and mental healthcare workers, that may not be easily facilitated if they are not a part of a multidisciplinary, integrated team. Altogether, the barriers to accessing care, the elevated rates of mental and physical health disparities, and the current requirement of a diagnosis of Gender Dysphoria by a mental health professional for a transgender individual to see other healthcare workers represent the multiple layers of barriers transgender individuals face when seeking health care. Throughout history, any healthcare worker has, in their own unique way, been considered to be a “gatekeeper,” as they are perceived
to hold power over transgender individuals based upon their position in providing a mental
health diagnosis, writing letters of recommendations for hormonal and/or surgical intervention,
and providing appropriate health care recommendations/services for this population. For
example, a speech language pathologist may not accept a transwoman as a patient who is seeking
vocal training, a physical therapist may not feel comfortable teaching a pregnant transman pelvic
floor exercises, or a medical receptionist may be uncertain how to ask demographic information
from a gender non-conforming individual. The consistent presence of these unfair power
dynamics, despite the continued effort of agencies, such as the WPATH, to eliminate them, gives
evidence as to why these barriers have persisted over time across health care settings. In
addition, it reinforces the need for providing transgender-affirmative care training for all
healthcare workers, as doing so may facilitate an improvement in collaborative care, and may
empower professionals to realize that “specialty” knowledge is not necessarily needed in order to
provide sufficient, and affirmative care.

A Movement Toward Integrating Transgender-Affirmative Healthcare Training

The historical approaches to health care for transgender individuals, although non-
affirmative at times (e.g., conversion therapy), have generally improved over the years regarding
facilitating access to routine care and transition support for transgender individuals. However,
there is still more progress to be made. Although the stigma regarding identifying as transgender
has decreased over time in the social realm, there are still many barriers that transgender
individuals face in the political and institutional (e.g., health care, insurance, employment)
realms that prevent them from fully embracing their authentic identities. Fortunately, the
modern consensus is moving to accept that the best approach to health care for transgender
individuals involves affirming and actively supporting a healthy development of one’s gender
identity (American Psychological Association, 2015; Austin & Craig, 2015; Coleman et al., 2012; Murad et al., 2010; Selvaggi & Bellringer, 2011; Selvaggi, Dhejne, Landen, & Elander, 2012). The push for progressive and affirmative approaches have been evident throughout history, as the original goal of the HBIGDA (and the continued goal of the WPATH) was to create a standardized approach to care for transgender individuals to facilitate collaboration among healthcare workers, and to eliminate the variation in pre-hormonal and surgical requirements that were articulated by individual clinics (e.g., Brown University, Johns Hopkins University, Stanford University, University of Texas, Galveston; Brody, 1979; Coleman et al., 2012; Naz Khan, 2016; Devor, 2019). The current version of the WPATH SOC (Coleman et al., 2012) are intended to be flexible in order to meet the diverse health care needs of all transsexual, transgender, and gender nonconforming individuals.

It is likely that the evolving changes to the SOC, although progressive and affirmative, have slowly been percolating into health care realms, whereas further training on transgender-affirmative approaches may aid in embracing the changes and the flexibility of the current standards. This has been echoed by healthcare workers expressing that they feel ill-informed on providing care for sexual and gender minority individuals. For example, Mitchell Lunn, a medical student at Stanford University School of Medicine, approached his faculty in 2007 asking to add more sexual and gender minority topics to their curriculum (Krisberg, 2016). At that time, the Association of American Medical Colleges (AAMC) recommended that medical schools, “ensure that students master the knowledge, attitudes, and skills necessary to provide excellent, comprehensive care for LGBT patients” (Awosogba et al., 2013, p. 23). Lunn and his classmates were curious if the curriculum of other medical schools were upholding this statement, initiating them to design a study surveying medical education deans in the United States and Canada.
States and Canada. They published their findings in the *Journal of the American Medical Association*, reporting that a median of five hours has been devoted to sexual and gender minority care in the medical school curriculum, and that more than one-third of survey respondents reported receiving zero hours of training in that specific type of care (Obedin-Maliver et al., 2011). It has been found that training on transgender-specific care is often embedded within discussions regarding LGBTQ health disparities at large, and that those trainings predominately focus on topics such as sexual orientation, HIV, gender identity, and safer sex; leaving transgender-specific topics, such as transitioning and gender-affirming procedures or surgeries, to be less frequently discussed. Additional studies have investigated the time dedicated to training on transgender-specific care both in graduate training and in the workplace. One study reported that 74% of students reported receiving less than two hours of coursework dedicated to transgender-specific care (Dowshen et al., 2016) and another study reported that 93% of respondents said that they have worked with less than five transgender patients, of which 40% cared for zero transgender patients during their training (Honigberg et al., 2017). However, in response to the call for an increase in transgender-specific health care training, there was a movement toward incorporating an inclusive curriculum. In 2014, the AAMC released the first guidelines to assist medical schools in training students to care for sexual and gender minority individuals, which included articulating 30 competencies that could be integrated into existing curricula (Krisberg, 2016).

Subsequently, several national sexual and gender minority health-focused organizations have developed materials to educate healthcare workers on providing affirmative care (e.g., Gay & Lesbian Medical Association, the Fenway Institute, and Center of Excellence for Transgender Health, The World Professional Association for Transgender Health, The Institute of Medicine,
World Health Organization, and the Endocrine Society). These organizations have played a critical role in the development, implementation, and monitoring of the impact affirmative-care training has on the health and well-being of transgender individuals, the attitudes healthcare workers have toward transgender individuals, and the level of confidence healthcare workers have in providing that care. In addition, recent changes to The Patient Protection and Affordable Care Act have, too, improved access to care for transgender individuals, but did not necessarily address the lack of healthcare worker training on transgender-affirmative care practices. Therefore, it seems critical that health care curricula needs to additionally be improved with the focus of improving healthcare workers’ attitudes toward and awareness of the transgender population, providing knowledge of transgender-specific care, and exposing healthcare workers to the efforts of the aforementioned sexual and gender minority health-focused organizations in order to address the longstanding transgender health inequities.

Contact as an Intervention

Intuitively, it seems that getting to know someone who is a member of a minority group will help to reduce stereotypes and prejudices that one has about that group. The psychological literature largely supports this notion. Allport (1954) was (one of) the first researchers who studied how contact interacts with prejudices toward minority groups. His influential work suggested that interactions between differing groups could, under certain conditions detailed below, result in a change in attitude toward one another. His work primarily focused on contact between racial majority and racial minority individuals, but the field has since been expanded to investigate contact between abled bodies and disabled bodies, cisgender and transgender individuals, and other majority-minority pairings. As a result of his work with racial groups,
Allport concluded that contact could perhaps act as an intervention regarding reducing stigma, prejudice, and discriminatory behaviors toward minority groups. He stated that:

“Prejudice (unless deeply rooted in the character structure of the individual) may be reduced by equal status contact between majority and minority groups in the pursuit of common goals. The effect is greatly enhanced if this contact is sanctioned by institutional supports (i.e., by law, custom, or local atmosphere), and if it is the sort that leads to the perception of common interest and common humanity between members of the two groups.” (Allport, 1954, p. 281).

This theory has been tested with various minority groups to observe the effect contact may have on groups with varying levels of stigma – originally in the context of racial minorities. For example, Frazier (1949) investigated contact between White and African American individuals, concluding that less contact was, indeed, associated with higher prejudice. Importantly, this work highlighted the importance of the conditions Allport articulated, as Frazier observed that there were several factors that created natural barriers for contact to occur throughout the study (e.g., segregation laws, disparities in class, education, socioeconomic status, tense social culture).

In addition to researching contact between racial groups, other scholars have investigated the effect contact may have on prejudices toward individuals with severe psychopathology, disabilities, and individuals with sexual and/or gender minority identities.

West, Hewstone, and Lolliot (2014) investigated if contact with individuals with a schizophrenia diagnosis would be associated with lower levels of stigma and prejudice. They discovered that prior contact was associated with less avoidance, less fear, and less anxiety related to contact with individuals with schizophrenia. Furthermore, Yuker and Hurley (1987) studied how contact with individuals with disabilities may affect attitudes, finding a strong effect
of contact on stigma. Research on contact with sexual and gender minority identities has yielded consistent findings as well: prior contact or increased contact with sexual or gender minority-identified individuals is often associated with fewer negative attitudes, stereotypes, and prejudices, under certain conditions (Claman, 2009; Norton & Herek, 2013; Tee and Hegarty 2006; Tompkins et al., 2015). For example, Case and Stewart (2013) conducted a study that observed how contact may be used as an intervention to reduce prejudices, myth endorsements, and negative behaviors toward transgender identified individuals. They measured contact by using three conditions in which information was presented to participants: 1) a letter from a transgender individual to his parents; 2) a list of facts about transgender individuals, and; 3) a documentary of a college age transgender individual. Although Case and Stewart (2013) hypothesized that the media intervention would lead to the greatest reduction in anti-transgender prejudices, they did not find any one intervention to be more powerful than another. However, they did report that their participants’ level of anti-transgender prejudices decreased across all conditions based upon pretest-posttest differences. In addition, Tompkins and colleagues (2015) investigated how different types of contact may be related to differing levels of anti-transgender prejudice. They used similar “contact” condition as Case and Stewart (2013), but created a unique condition that measured how empathy may play a role in impacting prejudices (e.g., a perspective-taking task of writing a fictional coming out letter). They found that those who were in a condition that evoked empathy evidenced less anti-transgender prejudice via the posttest measure. Lastly, Reed's (2018) study measured how different types of contact (e.g., personal, educational, general media) may have an impact on levels of anti-transgender prejudice. Reed (2018) found that, as reports of contact across all categories, on average, increased, measures of anti-transgender prejudice, on average, decreased. In other words, for each additional report of
experiencing personal contact with an individual who identifies as transgender, or contact with educational or general media materials that depict or describe transgender identities and/or experiences, the participants’ average ratings on the measure of prejudice significantly increased, indicating an overall decrease in anti-transgender prejudice. It was found that personal contact had the largest association with anti-transgender prejudice, followed by educational contact and then general media contact. This finding, among others, supports previous research by highlighting the nuances in which “contact,” in a broad sense, may be associated with the amount of prejudice an individual holds (Case & Stewart, 2013; Frazier, 1949; Reed, 2018; Tompkins et al., 2015; Walch et al., 2012; West et al., 2014; Yuker & Hurley, 1987).

**Establishing an Effective Health Care Training Intervention**

Several recent studies have dedicated their efforts to identifying the gaps in educational curricula for healthcare workers, developing comprehensive training materials, and investigating the impact the implementation of their training materials may have on healthcare workers’ knowledge of appropriate care practices. In 2018, Dubin and colleagues conducted a structured search of five databases seeking articles that discussed medical education and transgender health. They reported that, of the 1,272 papers they reviewed, only 119 papers were considered to be relevant to their predefined criteria. In many cases, articles often broadly discuss LGBTQ health topics and may not specifically address the unique needs of the transgender population; thus, although those articles may comment on transgender topics, they do not necessarily contribute to the literature in a way that is currently needed. Dubin and colleagues thus considered the field of transgender-specific care to be “an emerging field with few best practices” (p. 378). What is clear is that there is a demand by healthcare workers, and their transgender patients, for
transgender-specific training to be a staple component of health care curricula, as well as accessible in continuing education trainings. They succinctly summarize their findings:

“Transgender health has yet to gain widespread curricular exposure, but efforts toward incorporating transgender health into both undergraduate and graduate medical educations are nascent. There is no consensus on the exact educational interventions that should be used to address transgender health. Barriers to increased transgender health exposure include limited curricular time, lack of topic-specific competency among faculty, and underwhelming institutional support. All published interventions proved effective in improving attitudes, knowledge, and/or skills necessary to achieve clinical competency with transgender patients” (p. 377).

As highlighted, it has consistently been found that exposure to inclusive training material, whether it be in school or in the workplace, in small quantities or large, will in fact improve healthcare workers’ knowledge and delivery of care for transgender individuals; however, it has been concluded that the best practices and approach to evaluating trainings remain uncertain (Bonvicini, 2017; Dubin et al., 2018). Since it is known that attitudes, knowledge, and skill development are the foundational components to establish clinical competency (Dubin, et al., 2018; Hollenbach, Eckstrand, & Dreger, 2014), it is critical to continually develop and test the effectiveness of trainings on transgender affirmative care by drawing upon the success highlighted by previous researchers. In doing so, the development of an effective training has the potential to add well-researched, comprehensive, specific, and accessible curriculum with related pre- and post-training measures to the literature for wider use.

Studies that have analyzed the outcomes and impact of transgender-specific health care trainings have done so by developing a training curriculum tailored to a given audience after
reviewing the literature, providing the training, and testing the effectiveness via pre- and post-training measures. For example, one research team developed a 10-session course that was offered over the lunch hour for health profession students (Braun et al., 2017). They utilized pre-, post-, and 3-month post-training questionnaires, as well as a measure of anti-transgender prejudice, to measure the influence the training had on knowledge, attitudes, and beliefs regarding transgender health. Similar to the current study, the researchers reported that they did not have access to funding to support the curriculum development and outcome measures; rather, they developed the materials based on consultations with experts in the field, reviewing the literature, and considering scheduling and resource constraints. They explained that portions of their curriculum were modified from the University of California San Francisco’s Transgender Health Course, and that they refined it based upon previous students’ feedback throughout the years. Their curriculum introduced participants to basic demographic information and transgender terminology, reviewed health disparities faced by transgender patients, and provided recommendations regarding medical and surgical options for individuals interested in a medical transition. Uniquely, half of the instructors that taught the curriculum over the 10 sessions identified as transgender; however, they did not explicitly measure the impact this may have had on the outcomes of their study. The majority of their participants were studying either pharmacy (48%), medicine (24%), and advanced practice nursing (17%), with the remaining studying nursing (doctorate), sociology (housed within the school of nursing), or dentistry. Braun and colleagues concluded that their course resulted in an improvement in short-term changes in transgender-specific knowledge and a decrease in anti-transgender prejudice (i.e., improved knowledge and attitudes measured by the immediate post-training questionnaire). Although they did not report effect sizes, their findings mentioned above were both at \( p < 0.01 \). They also
reported an improvement in long-term (i.e., 3-month post-training) retention of transgender-specific knowledge and favorable attitudes. Braun and colleagues did experience attrition in their 3-month post-training questionnaire (30.4% response rate), but despite this setback, they did not find any statistically significant decreases in knowledge or attitudes.

Similarly, Click and colleagues (2019) studied the effect an educational session on transgender health would have on first- and second-year medical students’ comfort with and perceived knowledge about transgender patients. They developed a half-day educational intervention delivered by attending physicians that focused on basic terminology, navigating electronic health records, and prescribing hormone therapy. Within the training, they incorporated a small group discussion and a question and answer session with a volunteer transgender patient. Click and colleagues created a pre- and post-training survey that was based on the educational content they provided, and addressed topics such as participant comfort interacting with a transgender individual, knowledge of basic transgender terminology, preference in working with transgender patients, and awareness of barriers to care and affirmative care practices. Indeed, they found that the participants’ comfort with transgender patients, as well as knowledge of transgender topics, barriers to care, and affirmative care practices, increased between pre- and post-training surveys.

In addition, Stroumsa and colleagues (2019) conducted a study investigating if exposure to “transgender and gender diverse (TGD) content” and “knowledge of TGD health care” (p. 1) was related healthcare workers’ level of anti-transgender prejudice. Instead of providing an intervention (i.e., training on transgender-affirmative care practices), they administered an online survey asking healthcare workers to reflect on the amount of formal education they received on TGD health care, as well as responding to a measure of anti-transgender prejudice. Stroumsa
and colleagues specifically targeted attending physicians, advanced practitioners, and medical residents. Their survey was developed through consultation with experts in the field, and through integrating items from similar research studies. The scale was comprised of items measuring knowledge of TGD patients, exposure to TGD people and educational content, levels of anti-transgender prejudice, and healthcare worker demographics. They found that healthcare worker knowledge of TGD health care was associated with anti-transgender prejudice, but that hours of formal and informal education were not necessarily significantly associated. In other words, increasing hours of educational exposure alone did not have a significant relationship with anti-transgender prejudice, meaning that greater efforts need to be made to address healthcare workers’ prejudices toward transgender individuals and their knowledge on how to affirmatively care for them above and beyond textbook material. Therefore, Stroumsa and colleagues concluded that, along with an increase in hours of education related to transgender topics, there is a need for broader efforts to address anti-transgender prejudices in society in general, which may be addressed through increased contact with transgender individuals and/or exposure to representations of this identification in different mediums (e.g., movies, books), as well as greater representation in educational curricula.

Each of these studies have prompted the current researcher to investigate the effect a transgender-affirmative care training may have on healthcare workers’ attitudes toward and knowledge of routine care and transition support for transgender individuals. It is clear that previous research indicates that an improvement and increase in exposure to transgender-specific health curricula result in improved knowledge and attitudes. However, several of these studies have been limited in their location and are specific in their target audience such that they are not inclusive of all healthcare workers. Therefore, the aim of the current study is to construct a
training that models the aforementioned studies, but also addresses the gap in the literature regarding reaching a broader audience (i.e., any healthcare worker), incorporating contact in multiple realms (i.e., personal, educational, and general media), and providing the training at multiple, diverse sites.

**Present Study and Hypotheses**

Research has previously demonstrated that the lack of transgender-affirmative care in health care settings has a detrimental effect on the social, emotional, and occupational functioning of transgender individuals (Grant et al., 2011; James et al., 2016; Krisberg, 2016; Obedin-Maliver et al., 2011). Previous studies have focused on a) assessing why healthcare workers may be hesitant to provide transgender-affirmative care (Shires, 2016); b) measuring how different degrees of contact with transgender individuals or materials that depict and/or describe transgender experiences identities and/or experiences may mitigate effects of anti-transgender prejudice (Case & Stewart, 2013; Claman, 2009; King, Winter, & Webster, 2009; Reed, 2018; Walch et al., 2012; Willoughby et al., 2011); and c) investigating how the lack of inclusive and affirmative care for transgender individuals may impact their health and well-being (Clements-Nolle et al., 2006; Grant et al., 2011; James et al., 2015; Kenagy, 2005; Marcellin, Scheim, Bauer, & Redman, 2013; Testa et al., 2012; Xavier et al., 2007). However, it has only been recent that research has focused on assessing the impact training on transgender-affirmative care may have on healthcare workers’ willingness to provide that specific type of care, as well as on their individual levels of anti-transgender prejudice.

Given that contact has been shown to be a powerful intervention in reducing prejudices and improving motivation for meaningful interactions with marginalized groups (e.g., Allport, 1979; Case & Stewart, 2013; Frazier, 1949; Reed, 2018; Tompkins et al., 2015; Walch et al.,
2012; West et al., 2014; Yuker & Hurley, 1987), it seemed fitting to develop a study involving an educational intervention on transgender-affirmative care that additionally includes both personal contact and references to general media outlets. In order to further advance the literature, the current study used a repeated-measures, longitudinal design to examine the effects a transgender-affirmative care training may have on healthcare workers’ levels of knowledge, comfort, and confidence in delivering routine care and transition support for transgender individuals, as well as on their levels of anti-transgender prejudice. Drawing from the surveys developed from previous studies, the current study asked a broad range of questions regarding healthcare workers’ levels and areas of training, personal experiences of contact with transgender individuals, contact with materials that depict and/or describe transgender identities and/or experiences, professional encounters with transgender patients, and general attitudes toward transgender individuals. This helped us to understand the immediate (i.e., directly post-training) and longer-term (i.e., 3-month post-training) impact the training had on healthcare workers’ attitudes toward and knowledge of the transgender community, as well as their willingness to provide routine care and transition support. This study took on a novel perspective by directly providing the intervention to healthcare workers and graduate professional students in health care programs in their professional setting (e.g., at staff meetings, during routine didactics, as an invited presentation), and measuring the immediate and longer-term impacts of the training. However, due to the COVID-19 pandemic that struck the United States during the data collection portion of this study, a proportion of the data was collected via virtual delivery of the training paired with electronic pre- and post-training surveys. See below for a further discussion on the impact COVID-19 had on the study methodology. Lastly, unique to this study as well was that
the individual providing the educational intervention also identifies as transgender, thus adding a layer of contact (i.e., personal), as well as a professional and patient perspective.

In the present study, participants engaged in an approximately 90-minute transgender-affirmative care training provided by the principal investigator (see the appendices for the full training curriculum). The training focused on presenting basic transgender terminology (e.g., defining sex and gender, discussing accurate pronouns), overviewing common barriers to care (e.g., stigma, insurance barriers), and providing suggestions to practice affirmative care for transgender individuals (e.g., updating EHRs, adapting traditional health care approaches). The training was split into two main foci, with the first half focusing on defining transgender identities and acknowledging and understanding barriers to care, and the second half focusing on overcoming barriers to care and creating a welcoming environment. More specifically, the first half provided information regarding the difference between sex, gender, and sexuality, discussed the differences between transgender and cisgender, overviewed the literature on gender identity development, and commented on insurance, routine, and transition-related barriers to care for transgender individuals along with the health outcomes (e.g., mental and physical health disparities). The second half proposed individual and organizational strategies to help healthcare workers understand ways to help overcome barriers to care. The proposed individual strategies generally included avoiding assumptions regarding gender identification, being cognizant of body language, addressing patients appropriately, providing anatomically appropriate care, using preferred language (e.g., pronouns, anatomy), and encouraging healthcare workers to apologize for mistakes. The proposed organizational strategies generally included creating gender neutral bathrooms, incorporating inclusive paperwork, organizing EHRs, reviewing the non-discrimination policy, adding LGBTQ office décor and handouts, and engaging in “safe-zone”
trainings (e.g., continued education). Lastly, participants were provided local and national resources that they could further look into to supplement their transgender-affirmative care training experience. This training curriculum was adapted from content created from previous successful trainings, a thorough review of the literature, and the principal investigators personal experience researching transgender health (Bonvicini, 2017; Braun et al., 2017; Dubin, et al., 2018; Hollenbach et al., 2014). Furthermore, prior to the current study, the principal investigator had provided iterations of this training on thirteen different occasions across eight different locations and had incorporated the feedback from healthcare workers over time, resulting in the current version of the training.

The training was preceded by a baseline survey (i.e., pre-survey) and followed by a post-training survey (see appendices for all of the pre- and post-training surveys). In general, the pre- and post-training surveys assessed healthcare workers’ understanding of the transgender community, the barriers they face when seeking health care, and what transgender-affirmative care looks like. Following the pre- and post-survey and the training itself, Qualtrics was utilized to deliver an online 3-month follow-up survey to measure the longer term impacts the training on transgender-affirmative care may have had.

Based on previous findings, several hypotheses were proposed for this study. First, in accordance with Allport’s (1954) social contact hypothesis, the researchers hypothesized that previous reported contact with transgender-identified individuals would be associated with lower levels of anti-transgender prejudices at pre-training survey measurement compared to those who have not had contact. Second, it was hypothesized that the transgender-affirmative care training would be associated with increasingly lower levels of anti-transgender prejudice at the post-training survey measurements (immediately post-training and at the 3-month follow-up). Third,
it was hypothesized that the transgender-affirmative care training would be associated with an increase in participants’ reported knowledge of basic transgender terminology, barriers to care, and affirmative care practices (i.e., awareness of transgender topics) at the post-training measurements.

**Methods**

**COVID-19 Impact on Data Collection and Methodology**

Data collection initially commenced in December of 2019. Between December of 2019 and February of 2020, six in-person trainings were provided and data were collected from 151 participants. Due to the implementation of “stay-at-home” orders in March of 2020 across the nation, all additionally scheduled in-person trainings were cancelled and potentially rescheduled for a later date. As the stay-at-home orders continued to be extended across states, it became clear that it was infeasible and unsafe to provide trainings and collect data in person for the foreseeable future. In response, the principal investigator submitted an IRB amendment to provide the training virtually, and to collect pre- and post-training surveys, in addition to the 3-month follow-up surveys, electronically. Following, the principal investigator pre-recorded the training to maintain the consistency of the delivery and to avoid technological/connectivity barriers, and programmed the pre- and post-training surveys onto Qualtrics. The surveys and video training link were initially disseminated to the five health care agencies that had an in-person training scheduled between March and May of 2020. In addition, the educational coordinators of those five health care agencies were welcomed to share the link with colleagues that they thought may be interested in further disseminating, and the link was also shared on several health care related listservs. Thus, the current study from here on out will be split into
“Study 1” (i.e., in-person trainings) and “Study 2” (i.e., virtual trainings) to appropriately analyze the differences between the methodologies.

**Participants**

Individuals were recruited by the principal investigator (PI) contacting health care agencies and offering to provide a free training on transgender-affirmative care to their staff and trainees (initially advertised as in-person, subsequently offered as virtual only). Points of contact at health care agencies (e.g., clinic managers, educational coordinators, etc.) were sent a recruitment e-mail (Appendix A) accompanied with an electronic flyer (Appendix B) describing the training and the credentials of the trainer (i.e., advanced graduate student in a clinical psychology Ph.D. program, PI). The snowball method of participant recruitment was additionally utilized, as the points of contact at health care agencies were welcomed to share the recruitment e-mail with other agencies that may have been interested. Participants were ineligible for the study if they were under the age of 18 and if they were not currently or in the past a healthcare worker or a student in a healthcare professional program. Across the in-person and virtual trainings, the participants were healthcare workers or trainees at hospitals, medical centers, universities, federally qualified health care centers, private practices, Veterans Affairs medical centers, and other health care settings that consented to participate in the data collection portion of the study. The study was approved through the sponsoring university’s Institutional Review Board.

**Measures**

*General Questionnaire*

Participants were asked to provide demographic and other general information, including: age, gender identity, sex assigned at birth, sexual orientation, race/ethnicity, and education level.
For participants who were currently students, they were asked about their current field of study, the degree they are currently seeking, the year they are in their program, what clinical placements they have had, and what type of health care setting they aspire to work in post-degree. Participants who were non-students (i.e., professionals) were asked about the state where they received their highest degree/certificate, the area of study for their highest degree/certificate, what type of job position they currently hold, what their current job title is, how many years they have been in their current job position, the type of health care setting they work in, how many patients they encounter on a daily basis, and how many years overall they have worked in a health care setting. All participants were asked if they consider their current place of practice to be rural or urban (with an “unsure” option) and were asked if they had attended the transgender-affirmative care training conducted by the principal investigator in the past.

**Scale Development: A New Measure of Anti-Transgender Prejudice**

One of the most widely used measure of anti-transgender prejudice is Hill and Willoughby’s (2005) Gender and Transphobia Scale. However, given that their scale has arguably outdated language (e.g., “If I found out that my best friend was changing their sex, I would freak out.”), as well as the current dearth of more empirically validated measures of ATP in the literature, we found it fit to continue working on developing a new scale to measure anti-transgender prejudice that incorporates more modern language and takes into consideration the evolving current social climate regarding transgender issues. This new scale, the Anti-Transgender Prejudice Scale (ATPS), was originally developed by a group of advanced students (both undergraduate and graduate) who are committed to research regarding experiences of sexual and gender minorities. This scale was originally piloted as a part of the principal
The ATPS is comprised of several original items from the GTS that measure overt transphobia, but also includes items that measure microaggressions (e.g., pronoun insensitivity), specific situational fears (e.g., bathroom/locker room encounters), and general misunderstandings of what it means to be transgender (e.g., conflating gender, sex, and sexuality). Items are rated on a 7-point Likert scale, with responses ranging from “strongly disagree” to “strongly agree.” A few example items from this scale include, “I would feel uncomfortable being in a bathroom with a transgender person;” “I would be uncomfortable learning about a transgender person’s surgery;” and “I would be proud to know someone who is transgender.” Scores are computed by calculating participants’ average response across all 30 items on the Likert scale (1 = “strongly disagree,” 7 = “strongly agree”), with consideration of twelve reverse-scored items (e.g., numbers 2, 6, 8, 10, 12, 14, 17, 19, 21, 24, 27, 30). Higher average scores on the ATPS indicate higher levels of anti-transgender prejudice. Although there are limited reliability estimates for this measure, the overall coefficient alpha yielded for its original use was .96.

**Pre- and Post-Training Survey and 3-Month Follow-Up Survey**

Although previous studies have developed a variety of pre- and post-training surveys, those surveys were developed to directly reflect the curriculum utilized in each given study. Given that a standardized training curriculum for transgender-affirmative care does not yet exist, the PI developed additional curricula and a related set of pre- and post-training surveys to further contribute to the literature.

Therefore, the pre- and post-training surveys were uniquely developed for the current study in order for the questions to directly pertain to the training curriculum. These surveys were developed by integrating relevant questions from existing surveys, consulting with healthcare
workers, and revising items several times with a group of undergraduate and graduate students who are committed to research regarding the experiences of sexual and gender minorities. For the pre-training survey, participants were first asked to provide information regarding how many transgender patients they have worked with in a health care setting, how many transgender individuals they have had personal contact with (outside of their professional practice), the current percentage of their patient panel who identify as transgender, and the number of hours of training they have received in school, in their workplace, and on their own regarding transgender-affirmative care. Following, the participants were asked to respond to 22 statements that touched on categories such as: basic transgender terminology (“I know the difference between sex and gender,” “I am comfortable asking about accurate pronouns”), barriers to care (“I understand the challenges transgender patients face in health care settings,” “I am aware of the insurance difficulties transgender patients often encounter”), and affirmative care practices (“I am knowledgeable about transition related care for transgender patients,” “I know everything that I need to know about transgender-affirmative care”). This scale will be referred to as the Awareness of Transgender Topics Measure (ATTM). Items on the ATTM are rated on a 7-point Likert scale, with responses ranging from “strongly disagree” to “strongly agree.” In addition, there are several reverse coded items to ensure participants are thoroughly reading each item. Scores are computed by calculating participants’ average response across all 22 items on the Likert scale (1 = “strongly disagree,” 7 = “strongly agree”), with consideration of six reverse-scored items (e.g., numbers 9, 11, 12, 14, 17, 20). Higher average scores on the ATTM indicate higher levels of awareness of transgender topics (i.e., basic transgender terminology, barriers to care, and affirmative care practices). No reliability estimates exist for this measure, as it was developed for the current study. Lastly, they were asked to respond to 30 statements measuring
levels of anti-transgender prejudice (i.e., the Anti-Transgender Prejudice Scale (ATPS), which was discussed in detail in the scale development section above).

For the post-training survey, participants completed the ATTM and ATPS. In addition, participants were invited to answer a few reflective questions querying about if the training would make a difference in the way they do their job, whether the training increased their knowledge and/or confidence in working with transgender patients, and if the training influenced their likelihood of referring a transgender patient to specialty care. The post-training survey also gave them opportunities to expand upon their thoughts, to discuss what aspects of the training were most helpful, and to provide suggestions on how to improve the training.

For the 3-month follow-up survey, participants completed the ATTM and ATPS. Following, they were invited to answer the same reflective questions as in the post-training survey, with the addition of questions regarding if they had any new transgender patients since the training, if they changed how they approach health care, if they sought out additional information on transgender-affirmative care, if they had more consultations or discussions regarding transgender care with colleagues, and if they helped educate their colleagues on transgender-affirmative care. The 3-month follow-up survey also gave them opportunities to expand upon their thoughts, to discuss what aspects of the training they incorporated into their practice, and provided a space for any open-ended remarks.

Procedure

Study 1: In-Person Training

Upon entering the setting to attend the transgender-affirmative care training, healthcare workers were informed that the training is accompanied by a research project, and that anyone is able, but not required, to participate. Those who did not consent to participate in the research
component were still invited to attend the training. Consenting participants were provided several materials, including an informed consent form, a piece of paper for them to document their e-mail address, and a packet containing all the survey materials. A research assistant distributed the materials in order to maintain separation from the trainer (i.e., principal investigator) and the collected data. Participants were first instructed to provide their consent to participate in the study (Appendix C), and they were reminded that their participation is on a volunteer basis and that their responses will remain confidential. All participants read that their participation in the current study is not linked to any other guaranteed benefits (e.g., continuing education credits, monetary compensation, performance evaluations), and that they could withdraw at any time. They were also made aware that participation includes minimal risks/discomforts, but that they may at times feel uncomfortable reflecting on their knowledge and/or attitudes toward transgender individuals. Research assistants collected informed consent forms after they were signed.

Following, they were asked to write their e-mail on the separate sheet of paper they were provided (Appendix D), and were reminded that their e-mail would be kept separate from their other materials. The participants were then prompted to open their pre-training survey packet (Appendix E). The pre-training survey initially asked them to create a unique identifier to maintain their confidentiality, and to link their pre- and post-training survey responses with their 3-month follow-up responses. The unique identifier included: first letter of the participant’s mothers’ first name, number of older brothers (living and deceased) the participant has, number representing the month the participant was born in, and the first letter of the participant’s middle name (if applicable; Yurek, Vasey, Havens, 2008). Participants were provided an example to help avoid any confusion, as they were asked to recall this unique identifier for the immediate
post-survey and when they were e-mailed a Qualtrics link for the 3-month follow-up survey. For each survey, they were provided a reminder regarding how they created their unique identifier. Following the initial creation of their unique identifier, they filled out the general questionnaire and began the pre-survey. As participants finished the pre-survey, the research assistant collected those and the papers with e-mail addresses and placed them in separate containers. Once all participants finished the pre-training survey, the training commenced (Appendix H).

At the conclusion of the training, participants were invited to ask any lingering questions. At the commencement of the formal training, the principal investigator left the room and invited individuals with lingering questions to bring them to the hallway when they were ready, and the research assistant handed out the post-training survey (Appendix F) and remained in the room to answer questions about the research component of the study. As participants completed the post-training survey, the research assistant collected them and put them in another separate container. Lastly, participants were reminded to anticipate receiving an e-mail for a 3-month follow-up survey. After completing all measures, participants were thanked for their participation in the study. Three months following the training, participants were e-mailed a link to Qualtrics, were reminded about their informed consent and the voluntary nature of the study, and were invited to complete the 3-month follow-up survey (Appendix G). At the conclusion of the 3-month follow-up survey, participants were thanked for their continued participation, and the survey closed.

**Study 2: Online Training**

As noted earlier, a virtual training--necessitated by the COVID-19 pandemic--was utilized for research purposes; this comprised Study 2. Prospective participants were sent an e-mail with an invitation to a free transgender-affirmative care training. Upon clicking the link to view the transgender-affirmative care training, healthcare workers were informed that the
training is accompanied by a research project, and they were prompted to provide their consent to participate in the study. Those who did not consent to participate in the research component were offered to be sent a separate link solely to the pre-recorded video training. Consenting participants received the same pre- and post-training surveys as in-person participants, just in an electronic form. Upon completion of the pre-survey, participants were directed to click on a link that brought them to a YouTube video of the pre-recorded training (Appendix I). After viewing the training, participants were reminded that they could e-mail the principal investigator with any lingering questions, and they were directed to return to the Qualtrics tab on their computer to complete the post-training survey. Participants who viewed the online training were sent the same 3-month follow-up electronic survey as in-person participants in Study 1.

Results

Descriptive Data for Study Measures

Demographics

Study 1. For this sample, there were six trainings involving 151 participants who consented to complete the study. Participants ranged in age from 22 to 62 years old (M = 25.6, SD = 5.2). Participants primarily identified within a binary version of sex assigned at birth (89 assigned female [58.9%] and 62 assigned male [41.1%]), but there was a slight variation regarding current gender identification endorsed (90 female identified [59.6%], 89 male identified [39.7%], and 1 preferred not to answer [0.7%]). The majority of participants identified as straight (145 [96%]), but other sexual orientations were endorsed (2 identified as bisexual [1.3%], 2 identified as another sexual orientation [1.3%], 1 identified as lesbian [0.7%], and 1 preferred not to answer [0.7%]). Additionally, the majority of participants identified their race/ethnicity as White (134 [88.7%]), with other identifications endorsed as well (7 identified as
another race/ethnicity [4.6%], 6 identified as Asian [4%], 1 identified as Hispanic/Latino(a) [0.7%], 1 identified as Black or African American [0.7%], 1 identified as American Indian or Alaska Native [0.7%], and 1 preferred not to answer [0.7%]).

Most participants had completed a bachelor’s degree (86 [56.9%]), with several others reporting different levels of completed schooling experience (37 with an associate’s degree or certificate [24.5%], 17 with a high school diploma or equivalent [11.3%], 9 with a doctoral degree [6%], and 2 with an “other” educational experience [1.3%]).

Participants were asked to disclose whether they were currently students, in which 145 identified themselves as currently enrolled students (96%), and 6 identified themselves as exclusively non-students (4%). For those who identified as students, they ranged from year 1 – 7 in their programs; for those who identified as non-students (i.e., healthcare workers), the years they have worked in a health care setting ranged from 1.5 – 21 years. The fields of study and the current job titles for these participants can be found in the notes section for Table 1.1.

The majority of participants considered their current place of practice to be urban (125 [82.8%]), with others reporting working in a rural setting (14 [9.3%]), and several being unsure how to categorize their place of practice (12 [7.9%]). Lastly, no one reported that they had attended a transgender-affirmative care training conducted by the principal investigator in the past, meaning that all of the participants were experiencing this particular training for the first time. See Table 1.1 for a further breakdown of the demographic characteristics for Study 1.

**Study 2.** For this sample, participants (N = 138) ranged in age from 18 to 70 years old (M = 37.0, SD = 12.3 (note: one participant preferred not to answer)). Participants primarily identified within a binary version of sex assigned at birth (116 assigned female [84.1%], 21 assigned male [15.2%], and 1 preferred not to answer [0.7%]), but there was a slight variation
regarding current gender identification endorsed (113 female identified [81.9%], 21 male identified [15.2%], 3 with another gender identification [2.2%], and 1 preferred not to answer [0.7%]). The majority of participants identified as straight (108 [78.3%]), but other sexual orientations were endorsed (11 identified as bisexual [8%], 11 identified with another sexual orientation [8%], 3 identified as gay [2.2%], 3 identified as lesbian [2.2%], and 2 preferred not to answer [1.4%]). Additionally, majority of participants identified their race/ethnicity as White (111 [80.4%]), with other identifications endorsed as well (13 identified as another race/ethnicity [9.4%], 5 identified as Asian [3.6%], 4 identified as Hispanic/Latino(a) [2.9%], 2 identified as Black or African American [1.4%], 2 preferred not to answer [1.4%], and 1 identified as American Indian or Alaska Native [0.7%]).

Most participants had completed a master’s degree (55 [40%]), with several others reporting different levels of completed schooling experience (45 with a bachelor’s degree [32.6%], 25 with a doctoral degree [18.1%], 6 with an associate’s degree or certificate [4.3%], 6 with a high school diploma or equivalent [4.3%], and 1 who preferred not to answer [0.7%]).

Participants were asked to disclose whether they were currently students, in which 47 identified themselves as currently enrolled students (34.1%), 90 identified themselves as exclusively non-students (65.2%), and 1 preferred not to answer (0.7%). For those who identified as students, they ranged from year 1 – 7 in their programs; for those who identified as non-students (i.e., healthcare workers), the years they have worked in a health care setting ranged from 1 month – 42 years. The fields of study and the current job titles for these participants can be found in the notes section for Table 1.2.

The majority of participants considered their current place of practice to be urban (71 [51.4%]), with others reporting working in a rural setting (45 [32.6%]), and several being unsure
how to categorize their place of practice (22 [15.9%]). Lastly, 6 participants (4.3%) reported that they had attended the transgender-affirmative care training conducted by the principal investigator in the past, meaning that majority of the participants (95.7%) were experiencing this particular training for the first time. See Table 1.2 for a further breakdown of the demographic characteristics for Study 2.

**Measures of Contact**

**Study 1.** Participants were asked to estimate the total number of transgender patients whom they have worked with in a health care setting. A note accompanied this question stating that, “When a question asks about transgender individuals, it is referring to individuals that have disclosed of their transgender identity through paperwork or in person (not an assumption).” Participants reported varying degrees of contact, ranging from 0 to 50 transgender patients ($M = 2.9, SD = 6.1$). Furthermore, participants were asked to estimate the total number of transgender individuals whom they have had contact with outside of health care settings (e.g., family, friends, acquaintances, co-workers, etc.). Similarly, participants reported varying degrees of contact, ranging from 0 to 30 transgender individuals ($M = 2.8, SD = 4.8$). Lastly, participants were asked to approximate how many hours of training on transgender-affirmative care they received in their school curriculum, workplace/assistantship, and on their own, each respectively. The majority of participants reported receiving zero hours in school curriculum (129 [85.4%]; 22 receiving 1 – 2 hours [14.6%]), zero hours at their workplace/assistantship (125 [82.8%]; 21 receiving 1 – 2 hours [13.9%], 4 receiving 3 – 4 hours [2.6%]), and 1 receiving 5 – 6 hours [0.7%]), and zero hours on their own (111 [73.5%]; 24 receiving 1 – 2 hours [15.9%], 12 receiving 3 – 4 hours [7.9%], 2 receiving 5 – 6 hours [1.3%], and 2 receiving 7 – 8 hours [1.3%]). See Table 2.1 for a further breakdown of the measures of contact for Study 1.
**Study 2.** Participants reported varying degrees of professional contact, ranging from 0 to 70 transgender patients ($M = 4.6, SD = 8.5$). Similarly, participants reported varying degrees of non-professional contact, ranging from 0 to 100 transgender individuals ($M = 5.5, SD = 11.8$). In regards to the amount of hours of training on transgender-affirmative care participants received, the majority of participants reported receiving zero hours in school curriculum (83 [60.1%]; 34 receiving 1 – 2 hours [24.6%], 16 receiving 3 – 4 hours [11.6%], 2 receiving 5 – 6 hours [1.4%], 2 receiving 7 – 8 hours [1.4%], and 1 receiving 9 – 10 hours [0.7%]), zero hours at their workplace/assistantship (77 [55.8%]; 32 receiving 1 – 2 hours [23.2%], 12 receiving 3 – 4 hours [8.7%], 7 receiving 5 – 6 hours [5.1%], 4 receiving 7 – 8 hours [2.9%], and 6 receiving >10 hours [4.3%]), and zero hours on their own (51 [37%]; 36 receiving 1 – 2 hours [26.1%], 19 receiving 3 – 4 hours [13.8%], 11 receiving 5 – 6 hours [8%], 5 receiving 7 – 8 hours [3.6%], 1 receiving 9 – 10 hours [0.7%], and 15 receiving >10 hours [10.9%]). See Table 2.2 for a further breakdown of the measures of contact for Study 2.

**Awareness of Transgender Topics Measure**

**Study 1.** Participants’ average ratings on the total 22-item ATTM pre-training survey ranged from 2.27 to 5.59, with higher average ratings indicating greater awareness of transgender topics ($M = 3.95, SD = 0.67$). Their average rating on the ATTM post-training survey ranged from 3.68 to 6.18 ($M = 5.08, SD = 0.51$). Lastly, participants’ ($n = 48$) average ratings on the ATTM 3-month follow-up survey ranged from 3.45 to 6.05 ($M = 4.88, SD = 0.53$). See Table 3.1 for a further breakdown of the Awareness of Transgender Topics Measure for Study 1.

**Study 2.** Participants’ average ratings on the ATTM pre-training survey ranged from 2.32 to 6.14 ($M = 4.34, SD = 0.79$). Their average ratings on the ATTM post-training survey ranged from 3.59 to 6.50 ($M = 5.35, SD = 0.53$). Lastly, participants’ ($n = 48$) average ratings on
the ATTM 3-month follow-up survey ranged from 4.09 to 6.14 \((M = 5.33, SD = 0.50)\). See Table 3.2 for a further breakdown of the Awareness of Transgender Topics Measure for Study 2.

**Anti-Transgender Prejudice Scale**

**Study 1.** Participants’ average ratings on the total 32-item ATPS pre-training survey ranged from 1.07 to 6.37, with higher average ratings indicating more *negative* attitudes toward transgender persons \((M = 2.65, SD = 0.94)\). Their average ratings on the ATPS post-training survey ranged from 1.10 to 6.27 \((M = 2.44, SD = 0.94)\). Lastly, participants’ \((n = 48)\) average ratings on the ATPS 3-month follow-up survey ranged from 1.10 to 6.13 \((M = 2.31, SD = 0.94)\). See Table 4.1 for a further breakdown of the Anti-Transgender Prejudice Scale for Study 1.

**Study 2.** Participants’ average ratings on the ATPS pre-training survey ranged from 1.03 to 4.30 \((M = 2.01, SD = 0.73)\). Their average ratings on the ATPS post-training survey ranged from 1.00 to 4.07 \((M = 1.81, SD = 0.65)\). Lastly, participants’ \((n = 48)\) average ratings on the ATPS 3-month follow-up survey ranged from 0.97 to 3.73 \((M = 1.72, SD = 0.63)\). See Table 4.2 for a further breakdown of the Anti-Transgender Prejudice Scale for Study 2.

**Test of Hypotheses**

**Hypothesis 1**

It was first hypothesized, in accordance with Allport’s (1954) social contact hypothesis, that reported prior contact with transgender-identified individuals would be associated with lower levels of anti-transgender prejudices at the pre-training survey measurement, compared to those who have not had contact.

**Study 1.** An independent-samples *t*-tests comparing means for the dependent variable of anti-transgender prejudice by contact (i.e., dummy coded to “yes” for those who reported one or more personal or professional contact experiences and “no” for those who did not report any
contact) at the pre-training survey measurement did not yield significant differences. The participants with personal contact ($n = 121; M = 2.60, SD = 0.91$), when compared to participants with no personal contact ($n = 30; M = 2.84, SD = 1.05$), did not exhibit a significantly lower average rating (i.e., high average ratings indicate more prejudice) on the Anti-Transgender Prejudice Scale (ATPS), $t(149) = 1.265, p > .05$. These results suggest that previous personal contact, in this context, was not associated with lower levels of anti-transgender prejudice, compared to those without contact, prior to any interventions (i.e., at baseline). See Table 5.1 for a further breakdown.

**Study 2.** An independent-samples $t$-test comparing means for the dependent variable of anti-transgender prejudice by contact at the pre-training survey measurement did not yield significant differences. The participants with personal contact ($n = 121; M = 1.97, SD = 0.71$), when compared to participants with no personal contact ($n = 17; M = 2.32, SD = 0.82$), did not exhibit a significantly lower average rating on the ATPS, $t(136) = 1.919, p > .05$. This finding falls in line with the results of Study 1. See Table 5.2 for a further breakdown.

**Study 1 and 2: combined samples.** An independent-samples $t$-test comparing means for the dependent variable of anti-transgender prejudice by contact at the pre-training survey measurement, when combining the samples of Study 1 and 2, did yield significant differences. The participants with personal contact ($n = 242; M = 2.28, SD = 0.87$), when compared to participants with no personal contact ($n = 47; M = 2.65, SD = 1.00$), exhibited a significantly lower average rating on the ATPS, $t(287) = 2.65, p < .05$. This finding will be further described in the discussion section.
Hypothesis 2

Second, it was hypothesized that the transgender-affirmative care training would be associated with increasingly lower levels of anti-transgender prejudice at post-training survey measurements.

**Study 1.** A paired samples t-test comparing the means for the dependent variable of anti-transgender prejudice by time (i.e., pre- versus immediate post-training measurement) revealed significant differences. Participants’ immediate post-training measurement ($M = 2.44, SD = 0.94$), when compared to their pre-training measurement ($M = 2.65, SD = 0.94$), exhibited a significantly lower average rating (i.e., less prejudice) on the ATPS, $t(150) = -8.445, p < .001$. Calculations of effect size revealed a small effect, $d = 0.22$. A separate paired samples t-test was conducted to compare the means for the dependent variable of anti-transgender prejudice by post-training measurements (i.e., immediate-post versus 3-month post-training measurement), yielding significant differences; however, the difference observed between the immediate-post and 3-month post-training measurement was in the opposite direction of the second hypothesis. For those who participated in the 3-month follow-up survey ($n = 48$, or $31.8\%$), their 3-month post-training measurement ($M = 2.31, SD = 0.94$), when compared to their immediate post-training measurement ($M = 2.06, SD = 0.97$), exhibited a significantly higher average rating on the ATPS, $t(47) = 4.279, p < .001$. See Table 6.1 for a further breakdown.

**Study 2.** A paired samples t-test comparing the means for the dependent variable of anti-transgender prejudice by time revealed significant differences. Participants’ immediate post-training measurement ($M = 1.81, SD = 0.65$), when compared to their pre-training measurement ($M = 2.01, SD = 0.73$), exhibited a significantly lower average rating on the ATPS, $t(137) = -8.128, p < .001$. Calculations of effect size revealed a small effect, $d = 0.29$. A separate paired
samples $t$-test was conducted to compare the means for the dependent variable of anti-transgender prejudice by post-training measurements. For those who participated in the 3-month follow-up survey ($n = 48$, or 34.8%), their 3-month post-training measurement ($M = 1.72$, $SD = 0.63$), when compared to their immediate post-training measurement ($M = 1.67$, $SD = 0.58$), did not yield a significant difference, $t(47) = 1.336$, $p = .188$. See Table 6.2 for a further breakdown.

**Study 1 & 2: pre-training versus 3-month post-training.** A paired samples $t$-test comparing the means for the dependent variable of anti-transgender prejudice by time (i.e., pre-training measurement versus 3-month post-training measurement) revealed significant differences for Study 2 ($t(47) = -0.1688$, $p < .001$), but not Study 1 ($t(47) = -0.0445$, $p = 0.424$). See the general trends in mean differences across all three measurements in Figures 2.1-2.2. These findings are further explored in the discussion section.

**Hypothesis 3**

Last, it was hypothesized that the transgender-affirmative care training would be associated with an increase in participants’ reported knowledge of basic transgender terminology, barriers to care, and affirmative care practices.

**Study 1.** A paired samples $t$-test comparing the means for the dependent variable of awareness of transgender topics by time (i.e., pre- versus immediate post-training measurement) revealed significant differences. Participants’ immediate post-training measurement ($M = 5.08$, $SD = 0.51$), when compared to their pre-training measurement ($M = 3.95$, $SD = 0.67$), exhibited a significantly higher average rating (i.e., high average ratings indicate an increase in knowledge of basic transgender terminology, barriers to care, and affirmative care practices) on the Awareness of Transgender Topics Measure (ATTM), $t(150) = 26.198$, $p < .001$. Calculations of effect size revealed a large effect, $d = 1.9$. A separate paired samples $t$-test was conducted to
compare the means for the dependent variable of awareness of transgender topics by post
training measurements (i.e., immediate-post versus 3-month post-training measurement),
yielding significant differences; however, the difference observed between the immediate-post
and 3-month post-training measurement was in contradiction to the third hypothesis. For those
who participated in the 3-month follow-up survey (n = 48, or 31.8%), their 3-month post-training
measurement (M = 4.88, SD = 0.53), when compared to their immediate post-training
measurement (M = 5.20, SD = 0.49), exhibited a significantly lower average rating on the
ATTM, t(47) = -5.69, p < .001. See Table 7.1 for a further breakdown.

**Study 2.** A paired samples t-test comparing the means for the dependent variable of
awareness of transgender topics by time revealed significant differences. Participants’
immediate post-training measurement (M = 5.35, SD = 0.53), when compared to their pre-
training measurement (M = 4.34, SD = 0.79), exhibited a significantly higher average on the
ATTM, t(137) = 20.668, p < .001. Calculations of effect size revealed a large effect, d = 1.51. A
separate paired samples t-test was conducted to compare the means for the dependent variable of
awareness of transgender topics by post training measurements, yielding results similar to those
in Study 1. For those who participated in the 3-month follow-up survey (n = 48, or 34.8%), their
3-month post-training measurement (M = 5.33, SD = 0.5), when compared to their immediate
post-training measurement (M = 5.56, SD = 0.46), exhibited a significantly lower average rating
on the ATTM, t(47) = -4.403, p < .001. See Table 7.2 for a further breakdown.

**Study 1 & 2: pre-training versus 3-month post-training.** A paired samples t-test
comparing the means for the dependent variable of awareness of transgender topics by time (i.e.,
pre-training measurement versus 3-month post-training measurement) revealed significant
differences for Study 1 (t(47) = 0.7727, p < .001) and 2 (t(47) = 0.7756, p < .001). See the
general trends in mean differences across all three measurements in Figures 1.1-1.2. These findings are further explored in the discussion section.

Discussion

General Discussion

The current study utilized a longitudinal design by incorporating the results of the pre-, post- and 3-month follow-up survey results. Such a design afforded the ability to examine the longer-term impact a transgender-affirmative care training may have had on healthcare workers’ and trainees’ prejudices, confidence, competence, and likelihood of engaging in affirmative care practices for transgender patients. This was especially timely given the documented call for increased specialty health care training, as well as the lack of a standardized curriculum or outcome measurements of the efficacy of existing curricula. The purpose of this study was to explore the impact contact with a transgender-affirmative care training may have on healthcare workers’ and trainees’ attitudes toward and knowledge of routine care and transition support for transgender individuals. Research demonstrates that anti-transgender prejudices are highly detrimental to the social, emotional, and occupational aspects of transgender individuals’ lives – including their physical and mental health. To this end, the study tested and partially supported two of three hypotheses that examined the relationship between contact with transgender-identified individuals, as well as contact with an educational training on transgender-affirmative care, with levels of anti-transgender prejudice and awareness of transgender topics. Indeed, results found that contact with transgender-identified individuals or materials that depict or describe transgender identities and/or experiences has an important association with anti-transgender prejudices as well as awareness of transgender topics. We observed that this was especially true when considering the immediate impact the training had on pre- and immediate
post-training measurements of anti-transgender prejudice and awareness of transgender topics. There were, however, non-supportive, albeit unique, findings when comparing the immediate post and 3-month post-training measurements. Further interpretation of these findings will be discussed below.

**Hypothesis 1**

The first hypothesis proposed that previous reported contact with transgender-identified individuals would be associated with lower levels of anti-transgender prejudices at the pre-training survey measurement compared to those who have not had contact. Analyses revealed that there were no differences in mean scores of anti-transgender prejudice between those who reported having had contact with a transgender-identified individual compared to those who did not. This finding was consistent for Study 1 and 2. However, it is notable to mention that, when the samples from Study 1 and 2 were combined, we did observe a statistically significant difference in mean scores of anti-transgender prejudice. What this may illustrate is that each sample, when analyzed independently, did not have big enough sample sizes, leading to a lack of statistical power to observe statistical significance. Importantly, when combining the samples from the in-person and virtual trainings, we were able to fully support Hypothesis 1.

Although previous research has demonstrated that previous contact will typically be associated with lower levels of prejudice compared to those who have not had contact (Braun et al., 2017; Case & Stewart, 2013; Click and colleagues, 2019; Frazier, 1949; Reed, 2018; Stroumsa and colleagues, 2019; Tompkins et al., 2015; Walch et al., 2012; West et al., 2014; Yuker & Hurley, 1987), both samples in the current study, when analyzed independently, had a disproportionately high amount of participants who reported having had contact compared to other studies. In Study 1, we saw that 80.13% of participants reported having *at least one*
encounter with a transgender-identified individual in a personal (e.g., family member, friend) and/or professional (e.g., patient, co-worker) context. As a result, the comparison groups were unequal (i.e., we do not have equal representation of those with contact versus no contact), leading to biased comparisons of contact and its relationship with anti-transgender prejudice prior to the educational intervention.

Furthermore, previous research has asserted that certain demographic characteristics (e.g., higher education, female-identification, etc.; Norton & Herek, 2013; Reed, 2018; Testa et al., 2015) have demonstrated strong relationships with more favorable attitudes toward minority groups, including transgender-identified individuals. For Study 1, over half (56.9%) of the participants had completed a bachelor’s degree, in which 96% of the sample were students currently enrolled in a graduate program (and the remaining 4% were doctoral level healthcare workers; Note: for this sample, a significant proportion of participants were pharmacy students, in which their degree seeking pathway is streamlined to their graduate degree, leading to the mismatch between completion of bachelor’s degrees and students currently enrolled in a graduate program), and nearly 60% self-identified as female. In Study 2, we saw that 87.7% of participants reporting having at least one encounter with a transgender-identified individual in a personal and/or professional context, leading to unequal comparison groups similar to that of Study 1. In addition, a significant proportion of participants (90.7%) reported having at least a bachelor’s degree (34.1% being currently enrolled students and 65.2% being healthcare workers), and over three-quarters (82%) self-identified as female. Overall, it is not surprising that the current study’s samples revealed lower prejudices at the baseline measurement, notwithstanding participants’ degree of contact. Altogether, the lower baseline measures of anti-transgender prejudice may be attributable to the sample demographics, and may be related to the
non-significant differences observed between those with and without contact with a transgender individual. What these results reinforce, though, is that contact, indeed, is related to lower levels of anti-transgender prejudice, and that contact with individuals who identify as transgender or materials that depict and/or describe transgender identities and/or experiences should be further advocated for.

**Hypothesis 2**

The second hypothesis proposed that the transgender-affirmative care training would be associated with increasingly lower levels of anti-transgender prejudice at post-training survey measurements. In partial support of this hypothesis, it was found that there was a significant decrease in mean scores on the ATPS between the pre- and immediate post-training measurement for Study 1 and 2. This means that participants, on average, endorsed less anti-transgender prejudice sentiments directly after attending (or viewing) the training on transgender-affirmative care than they did prior to the training. This finding reinforces the results found by Braun and colleagues (2017) as well as Click and colleagues (2019), whereas both studies resulted in a short-term decrease in anti-transgender prejudices. In addition, these results support Allport’s (1954) original contact hypothesis and extensions of it (e.g., Reed, 2018), as exposure to transgender identified individuals, educational materials, and/or general media outlets that depict or describe transgender identities or experiences have been found to be associated with lower levels of anti-transgender prejudice. Interestingly, we observed an increase in anti-transgender prejudice between the immediate post-training and 3-month post-training measurements in Study 1, and no significant changes in Study 2, indicating that the immediate changes observed were only temporary or short-term. Braun and colleagues (2017) alluded to a similar phenomenon, but concluded that the attrition they experienced at their 3-
month follow-up lead them to cautiously interpret their findings. For Study 1, we saw a 31.79% response rate (i.e., 68.21% attrition rate), which was slightly higher than Braun and colleagues’ 3-month follow-up response rate (30.4%). Therefore, these results should be interpreted cautiously given the rate of attrition, as they may not be fully representative of the total samples.

In addition, it seems evident that participants may be experiencing an effect similar to that known as the Dunning-Kruger effect, which is described as “being ignorant of one’s own ignorance” (Dunning, 2011, pg. 1). As such, after being removed from the original training for three months, participants had time to reflect on their own prejudices and lack of knowledge, and at the 3-month post-training measurement may have been more aware of what they did not know before. As a result, they may have been more cognizant of their implicit and/or explicit prejudices, as well as their fundamental lack of knowledge on transgender-affirmative care (as evidenced by the pre-survey measurement), leading to the results appearing in the opposite direction as hypothesized. However, there was a statistically significant difference between the average scores on the pre-training and 3-month post-training measurements, reinforcing the important association demonstrated between the educational intervention and levels of anti-transgender prejudice. Furthermore, as evidenced for Study 1 and 2 in Figures 2.1-2.2, we see an important general trend regarding a decrease in anti-transgender prejudice, despite the lack of statistical significance between the immediate-post and 3-month post-training measurements.

Nevertheless, the significant increase in prejudice is not a novel phenomenon (Braun et al., 2017; Hill & Augoustinos, 2001; Stroumsa et al., 2019), and may be attributed to multiple factors, such as participants’ reflection and awareness of their subtle and/or implicit prejudices, being removed from the topic at hand (i.e., transgender-affirmative practices) and not re-engaging with it during the 3-month time period, the current worldwide pandemic influencing
their typical practice (i.e., COVID-19), among other explanations. What this result does exemplify, though, is that an increase in exposure to transgender-affirmative care, as well as consistent continued education, may be key to decreasing prejudices and observing a maintenance in those lower levels of prejudice.

**Hypothesis 3**

The third hypothesis proposed that the transgender-affirmative care training would be associated with an increase in participants’ reported knowledge of basic transgender terminology, barriers to care, and affirmative care practices. In partial support of this hypothesis, it was found that there was a significant increase in mean scores on the ATTM between the pre- and immediate post-training measurements for Study 1 and 2. This means that participants, on average, exhibited more awareness of transgender topics directly after attending the training on transgender-affirmative care than they did prior to the training. This finding further reinforces the results of Braun and colleagues (2017), Click and colleagues (2019), as well as Stroumsa and colleagues (2019), who reported an improvement in short-term changes in transgender-specific knowledge (e.g., specific transgender topics, barriers to care, and affirmative care practices). Similar to the phenomenon discussed in the Hypothesis 2 section, we observed a *decrease* in awareness of transgender topics between the immediate-post and 3-month post-training measurement, indicating that the immediate changes observed were only temporary or short-term. The general interpretation of this result falls in line with the discussion posed in the Hypothesis 2 section above. We again may be observing a Dunning-Kruger like effect, such that participants at the 3-month follow-up survey may have been increasingly aware of what they did not know, and perhaps still do not know, after attending the training. Similarly, we found a statistically significant difference between the average scores on the pre- and 3-month post-
training measurements, reinforcing the important association demonstrated between the educational intervention and levels of awareness of transgender topics. According to Figures 1.1-1.2, we similarly see a general upward trend regarding knowledge of transgender-affirmative care practices, despite the lack of statistical significance between the immediate-post and 3-month post-training measurement, signifying the importance of educational interventions to improve knowledge, awareness, and confidence.

In addition, the educational exposure of the samples from both Study 1 and 2 were similar to the findings published in a study by Obedin-Maliver and colleagues (2011), which stated that a median of five hours had been devoted to sexual and gender minority care in the medical school curriculum, but that more than one-third of their survey respondents reported receiving zero hours of training in transgender-specific type of care. For both Study 1 and 2, the majority of participants reported receiving zero hours of training in school, in their workplace/assistantship, and on their own. This is a unique finding because it highlights the lack of exposure to transgender-affirmative knowledge across multiple health care fields, not just medicine. As a result, it is not surprising that the retention of this relatively novel information may have been difficult for many participants, leading to the observed partial support of hypothesis three. The implications and suggested future directions to address the partial support of the latter two hypotheses will be further discussed below.

Implications

The aims of the current study were to contribute to the existing health care curricula by: 1) developing content that is easily consumable, evidence-based, and addresses basic transgender terminology, barriers to care transgender individuals currently (and historically) face, and affirmative approaches to routine care and transition support; 2) inviting all healthcare workers
in a given setting that impact the experience of a transgender patient to attend; and 3) integrating the multiple forms of contact (i.e., self-disclosure, educational content, and general media references) to further target attitudes. Despite the lack of support of Hypothesis 1 (when analyzing the study samples separately) and the partial support of Hypothesis 2 and 3, it seems clear that the study’s aims were largely met, and that participants benefitted from attending the training either in-person or virtually. Unique to this study was the integration of qualitative questions which allowed for participants to be active contributors to the continued development of this curriculum. In addition, the feedback from the participants contextualizes the findings, illustrates the direct implications, and provides a wealth of information regarding future directions for this program of research.

For Study 1, 71.5% either agreed or strongly agreed with the statement “I feel that attending this training will make a difference in the way I do my job.” One participant remarked, “I will keep the information in mind when interacting with patients and be more of an advocate instead of a silent supporter.” Another shared a specific example, “I feel like I am [an] inclusive person and do a fairly good job about respecting people. This training will make me be more careful about the words I say – such as “sir” and “ma’am.” For the statement, “This training has increased my knowledge on how to work with transgender patients,” 77.5% of participants either agreed or strongly agreed. One participant stated, “I feel I have more understanding towards treating our trans patients, and understand how much more there is to learn out there.” Another specifically stated that, “Learning sex vs. gender vs. sexuality really played an impact on my knowledge of the subject.” Lastly, 61.6% of participants either agreed or strongly agreed to the statement, “This training has increased my confidence in working with transgender patients.” One participant shared, “Now that I understand this subject better, I feel more qualified in
working with these patients.” Another shared, “I guess I didn’t know how to act before and this gave me confidence to just act normal and work with them just like anyone else.” These sentiments reflect comfort, confidence, and growth in understanding transgender patients, and reflect the helpfulness of receiving training on transgender-affirmative care. We also found that over half (56.3%) of the participants from Study 1 stated that they feel less likely to refer transgender patients out as a result of attending/viewing the training. This finding is critical, as it exemplifies the strength in empowering healthcare workers to directly provide the care to transgender individuals in need and not make unnecessary external referrals.

Findings from the 3-month follow-up survey for Study 1 (n = 48) also reinforce the implications of the study, as well as provide some evidence for the longer-term impact, despite the lack of statistically significant results to fully support Hypothesis 2 and 3. Over half (56.3%) of the participants either agreed or strongly agreed to the statement, “I feel that attending the training has made a difference in the way I do my job,” such as reflected by one participant, “The training made me aware of the challenges that a transgender patient faces every day, especially with insurance.” Similarly, over half (60.5%) either agreed or strongly agreed to the statement, “The training increased my knowledge on how to work with transgender patients.” Despite the partial support of Hypothesis 3 regarding longer-term increase in knowledge, one participant shared, “I have learned to separate gender, sex, and sexuality more. I was aware they were different but didn’t know how to learn to separate the concepts and understanding until this training. I have realized that I have a lot more learning and working on this knowledge in the future.” Relatedly, 47.9% of participants either agreed or strongly agreed with the statement, “The training increased my confidence in working with transgender patients, such as one participant reporting, “With more knowledge, I feel like I am more confident in the patient
population as well as being more confident in asking for help.” As a result, 52.1% reported that they have changed their approach to health care since the training, 25% have sought out additional information regarding transgender-affirmative care, 31% have consulted more with colleagues or had rich conversations regarding transgender-affirmative care, 31.3% have helped educate their colleagues on transgender-affirmative care, and 25% have incorporated some of the changes that were suggested in the training (e.g., locating gender-neutral bathrooms, checking intake paperwork, etc.).

For Study 2, 73.2% either agreed or strongly agreed with the statement “I feel that attending this training will make a difference in the way I do my job.” One participant remarked, “At my current job I have had no specific training to provide trans-centered care, this has been helpful. I do think my workplace should include this sort of training in the on-boarding process for new employees, and I am more likely no to point that out to my supervisor.” Another shared a specific example, “As a health psychology/behavioral medicine student, I am really interested in finding ways to better integrate aspects that are typically considered “physical health” with those that are typically considered “mental health,” and I think some of the helpful language [the speaker] provided around asking about anatomy could be really critical to getting important information about sexual health while continuing to provide affirmative care.” For the statement, “This training has increased my knowledge on how to work with transgender patients,” 81.9% of participants either agreed or strongly agreed. One participant stated, “I had a few misconceptions regarding transition, specifically typical age of transition, which the presentation dispelled. Moreover, I had not had previous formal exposure to use of pronouns, so that was helpful in the knowledge category as well.” Another specifically stated that, “I was not aware that the suicide rate for transgender individuals was so high.” Lastly, 73.2% of
participants either agreed or strongly agreed to the statement, “This training has increased my confidence in working with transgender patients.” One participant shared, “Every time I learn more about vulnerable populations, I feel more confident in my ability to meet their needs.” Another shared, “Having strategies to put in place increases my confidence.” We also found that over half (57.2%) of the participants from Study 2 stated that they feel less likely to refer out as a result of attending/viewing the training. These findings support the conclusions from Study 1, and it further reinforces the importance of promoting transgender-affirmative care trainings within health care fields.

Lastly, findings from the 3-month follow-up survey for Study 2 revealed that 68.8% of the participants either agreed or strongly agreed with the statement, “I feel that attending the training has made a difference in the way I do my job,” such as reflected by one participant: “This training has helped me feel more comfortable having conversations in the workplace. It [has] also been a good reminder that conversations around trans-affirmative care need to happen. It's important that my organization says we welcome everyone; this training has been a great reminder on how we need to work to make sure that everyone FEELS welcome.” Similarly, over three-quarters (81.3%) either agreed or strongly agreed to the statement, “The training increased my knowledge on how to work with transgender patients.” Despite the partial support of Hypothesis 3 regarding longer-term increase in knowledge, one participant shared, “I feel I have a better understanding of how a transgender person struggles when having to navigate healthcare and providers, and how they can be treated poorly in some cases” Relatedly, 79.2% of participants either agreed or strongly agreed to the statement, “The training increased my confidence in working with transgender patients, such as one participant’s reporting, “Before this training, I felt unsure about how to interact in a healthcare setting with a trans person. Now, it
seems much more approachable and I have more confidence in my knowledge and ability to serve the transgender community.” As a result, 64.6% reported that they have changed their approach to health care since the training, 66.7% have sought out additional information regarding transgender-affirmative care, 62.5% have consulted more with colleagues or had rich conversations regarding transgender-affirmative care, 52.1% have helped educate their colleagues on transgender-affirmative care, and 58.3% have incorporated some of the changes that were suggested in the training (e.g., locating gender-neutral bathrooms, checking intake paperwork, etc.). See Tables 8.1 – 13.2 for a full list of qualitative responses.

Based upon the findings, it is hopeful that this research will further validate the importance of providing transgender-affirmative care trainings more broadly, as well as advance the understanding the role anti-transgender prejudice has on perpetuating barriers to care. This study has further demonstrated the important association contact has with prejudices, and the evidence may afford more leverage in promoting an increase in transgender-affirmative care trainings in all health care settings. Altogether, the achievement of the aims of this study could provoke the subsequent development of field-specific or institution-wide mandatory transgender-affirmative care trainings as a standard approach to reduce prejudice and improve the approach to health care.

Limitations and Future Directions

The present study has several notable limitations. The demographic composition of Study 1 consisted of healthcare workers and healthcare professional students limited to a select region of the United States (e.g., West Michigan), and were predominately in the field of pharmacy; thus, that sample is not representative of all health workers. In addition, the sample of Study 2 was dependent on the snowball recruitment methodology, thus leading to a biased
sample based on who received the study invitation. It would be beneficial in the future to not only include individuals from a diverse range of locations, professional backgrounds, ethnicities, races, and genders, but also to make the training increasingly accessible to any healthcare worker. Second, the principal investigator was both the researcher and trainer, thus making it difficult to address demand characteristics (i.e., participants potentially modifying their responses in reaction to the purpose of the study). Future studies could benefit from having an independent research group assess the effectiveness of a transgender-affirmative care training to remove the influence of demand characteristics or other confounding variables. Third, the current research was not an experimental design, and thus cannot assert the long-term impacts a transgender-affirmative care training may have on healthcare workers’ delivery of transgender-affirmative care, as it does not include a control group to differentiate training effects from a “non-training” condition. Future studies should consider including a control group in order to differentiate the effects the live or virtual training has on anti-transgender prejudice and awareness of transgender topics compared to other delivery methods (e.g., reading articles, attending a panel discussion, etc.). Furthermore, the initial planned analyses were to compare the 3-month follow-up training scores with the pre- and immediate post-training scores from the majority of the participants in order to measure the longer-term impact. In addition, if future studies secure funding to provide incentives for their full participation (i.e., pre, post, and 3-month follow-up surveys completed), they may experience less attrition between immediate post- and longer-term follow-up measurements. Fourth, although the training intended to be reasonably comprehensive, it by no means covered all of the aspects of providing transgender-affirmative care. Notably, the training was provided by an individual studying mental health; thus, the training naturally was limited in the scope of practice suggestions that could be
suggested (i.e., the trainer could not make medical recommendations regarding issues such as hormone replacement therapy or specific physical examinations). Future studies may benefit by collaborating with an interdisciplinary team to develop and deliver the curriculum in either one longer training, or across multiple trainings. Fifth, since several of the measures utilized in this study were being piloted, they lacked established validity and reliability. Although the use of these measures in this study will help establish validity and reliability estimates, future studies may benefit from continuing to validate these measure while also utilizing other established measures. Lastly, the live and virtual delivery of these training, along with the data collection, occurred during the unprecedented global pandemic, thus the health care delivery landscape drastically shifted and the availability for participation and data collection became limited, which perhaps influenced the findings presented in this manuscript. Future studies could consider replicating this project when the health care field returns to a consistent and familiar way of functioning.

Conclusion

It is undeniable that training on transgender-affirmative care is critical to improving the health and well-being of the transgender community. In order to achieve this, healthcare workers need to be aware of their own levels of anti-transgender prejudice and need to feel more confident and competent in delivering exemplary care for transgender patients. The current study supports the need for continued education on transgender topics, as well advocating for an increase in personal, educational, and general media contact as it relates to transgender individuals and/or their unique experiences. It has consistently been found that exposure to inclusive training material, whether it be in school or in the workplace, in small quantities or large, will in fact improve healthcare workers’ knowledge and delivery of care for transgender
individuals. This was exemplified through the findings of this study, despite its limitations, especially regarding the immediate impact training on transgender-affirmative care has on attitudes toward and knowledge of routine care and transition support. Since it is known that attitudes, knowledge, and skill development are the foundational components to establish clinical competency (Dubin, et al., 2018; Hollenbach, Eckstrand, & Dreger, 2014), it is critical to continually develop and test the effectiveness of trainings on transgender affirmative care by drawing upon the success highlighted by the current study, as well as previous researchers. In doing so, the further development of an effective training has the potential to add well-researched, comprehensive, specific, and accessible curriculum with related pre- and post-training measures to the literature for wider use.
References


Hollenbach, A., Eckstrand, K., Dreger, A. (2014). *Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD (1st ed.)*. Washington, DC: Association of American Medical Colleges

http://dx.doi.org/10.1016/j.socscimed.2015.11.010

Human Resources (2019). Who is considered a Health Care Provider/Practitioner? Retrieved from https://hr.berkeley.edu/node/3777


http://dx.doi.org/10.1080/19317610802434609


https://doi.org/10.1097/jnx.0000000000000249


http://dx.doi.org/weblib.lib.umt.edu:8080/10.1037/sgd0000138


https://doi.org/10.1177/0891243207306384


http://dx.doi.org/10.1037/0735-7028.33.3.249
Shires, D., Jaffee, Kim D., Patterson, D., Sung Hong, J., & Woodford, M. (2016). *Factors Associated with Primary Care Providers' Willingness to Deliver Routine and Transition Care to Transgender Individuals*, ProQuest Dissertations and Theses.


http://dx.doi.org.weblib.lib.umt.edu:8080/10.1037/a0029604

http://dx.doi.org.weblib.lib.umt.edu:8080/10.1037/sgd0000088


http://dx.doi.org.weblib.lib.umt.edu:8080/10.1080/15532739.2010.550821


Appendix A

E-mail Recruitments

Study 1:

Subject Line: Free Training on Transgender-Affirmative Care

Hello!

My name is Oak Reed and I am a 5th year doctoral candidate in clinical psychology at the University of Montana. I am reaching out to you to see if you are interested in me providing a free 1-hour training to your staff on transgender-affirmative care. My training involves providing information on basic transgender terminology and common barriers to care that transgender patients often encounter, as well as suggesting individual and organizational strategies to help overcome those barriers to care.

This training acts as a part of my dissertation research project, and is accompanied with a pre- and post-training survey (each take 10-15 minutes to complete); however, participation in the research component is completely voluntary. In addition, those who consent to participate will be e-mailed a follow-up survey 3 months after the training. The purpose of this study is to help improve health care curriculum by making it increasingly comprehensive.

I welcome all staff to attend the training, ranging from administrative staff to physicians. I am happy to provide additional information regarding this training at any time, feel free to e-mail me at oakleigh.reed@umontana.edu or by phone at 231-343-0076.

I look forward to further connecting!
-Oak Reed

This project has been approved by the University of Montana's Institutional Review Board, protocol #176-19
Study 2:

Subject Line: Free Virtual Training on Transgender-Affirmative Care

Hello!

Since we were unable to meet in person for the training on transgender-affirmative care, I have programmed everything online so that folks can participate at a time that is convenient for them. We will not let the COVID-19 crisis stop us from continuing our education!

Clicking the link below will bring you to a Qualtrics survey that will jump-start the virtual training on transgender-affirmative care:

https://umt.coI.qualtrics.com/jfe/form/SV_3aPz7d8KOi8V7Ap

As a reminder, this training acts as a part of my dissertation research project, so folks will first be prompted to complete a pre-training survey before being directed to the training video. Following the training, folks will be given directions on how to complete the post-training survey (each take a few minutes to complete). Participation in the research component is completely voluntary, and those who consent to participate will be e-mailed a follow-up survey 3 months after the training. The purpose of this study is to help improve health care curriculum by making it increasingly comprehensive.

I welcome all staff to attend the training that have availability, such as administrative staff, medical assistants, pharmacists, physical therapists, and physicians, to name a few. I am happy to provide additional information regarding this training at any time - feel free to e-mail me at oakleigh.reed@umontana.edu or by phone at 231-343-0076.

Feel free to forward this e-mail to anyone else who may be interested.

Stay healthy!
-Oak

This project has been approved by the University of Montana's Institutional Review Board, protocol #176-19
Appendix B

Recruitment Flyer

TRANS-AFFIRMATIVE CARE TRAINING
IDENTIFYING & OVERCOMING BARRIERS TO CARE FOR TRANSGENDER PATIENTS

Oak Reed, M.A. is providing a 1-hour training on transgender-affirmative care that is free of charge. Oak has published both empirical and theoretical articles, book chapters, and book reviews on LGBT topics. In addition, he has been invited to lecture at several universities, provide didactic trainings to health care providers, and present his research at regional national conferences.

This training acts as a part of his dissertation research project and is accompanied with pre- and post-training surveys (each take 10-15 minutes to complete); however, participation in the research component is completely voluntarily and data is kept confidential. Interested participants must be 18 years or older and are health care workers/students.

Introduce important terminology

Discuss statistics regarding health disparities

Identify & analyze barriers to care

Overview strategies to create a welcoming environment

FREE OF CHARGE!

OAK REED, M.A.
Clinical Psychology
Doctoral Candidate
University of Montana

Oakleigh.reed@umontana.edu

E-mail now to inquire for a training!
Appendix C

Subject Information and Informed Consent

Study Title: Evaluating the Effectiveness of a Trans-Affirmative Care Training on Health Workers’ Attitudes Toward and Knowledge of Routine Care and Transition Support for Transgender Individuals

Investigators

Principal Investigator:
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Inclusion Criteria:

- Must be 18 years or older
- Must either:
  - Be employed in a health care setting
  - Be a student in a health-related field

Purpose:
Thank you for your interest in our study. The purpose of this study is to investigate the impact a trans-affirmative care training may have on health workers’ attitudes toward and knowledge of routine care and transition support for transgender individuals. You have been invited to participate because you are 18 years or older, work in a health care setting or are studying in a health-related field, and have expressed an interest in learning about trans-affirmative care.

Procedures:
If you agree to take part in this research study, you will first be given a pre-training survey that will take approximately 10 – 15 minutes to complete. Following, you will be provided a training on trans-affirmative care that overviews current and historical barriers to care, as well as strategies to overcome those barriers. The training will last approximately 1 hour. After the training, you will be given a post-training survey that will take approximately 10 – 15 minutes to complete. Lastly, you will be e-mailed a link to a 3-month follow-up survey that will take approximately 10 – 15 minutes, if you desire to complete it.

Risks/Discomforts:
Although risk to participants is anticipated to be minimal, there is a chance that some discomfort may be experienced regarding disclosing of attitudes toward and knowledge of transgender individuals.
Benefits:
There is no promise that you will receive any benefit from taking part in this study. However, you will receive the benefit of knowing you are contributing to the larger body of knowledge focusing on improving the delivery of routine- and transition-related care for transgender individuals. Your participation in this study may help further understand the barriers to care transgender individuals face, and may help improve health care providers’ training both in their educational training and in the workplace.

Confidentiality:
Your records will be kept confidential and will not be released without your consent except as required by law. The data will be stored in a locked file cabinet and on a password protected computer, and your signed consent form will be stored in a cabinet separate from the data.

Voluntary Participation/Withdrawal:
Your decision to take part in this research study is entirely voluntary. You may refuse to take part in or you may withdraw from the study at any time without penalty or loss of benefits to which you are normally entitled.

Future Research:
Identifiers might be removed from the identifiable private information and could then be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you or your legally authorized representative.

Questions:
If you have any questions about the research now or during the study, please contact: Oakleigh Reed at (231)-343-0076 or oakleigh.reed@umontana.edu, or Bryan Cochran at (406)-243-2391 or bryan.cochran@umontana.edu. If you have any questions regarding your rights as a research subject, you may contact the UM Institutional Review Board (IRB) at (406)-243-6672.

Statement of Your Consent:
I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand I will receive a copy of this consent form, if requested.

Printed Name of Participant

Participant's Signature

Date

The University of Montana IRB
Expiation Date
Date Approved
Chair Admin
Appendix D

Participant E-Mail

In the space below, please write your e-mail as clearly as possible to receive the 3-month follow-up survey. This information will be kept separate from your informed consent and survey responses in order to maintain your confidentiality.

_____________________________________________________________________________
Participant’s E-mail Address
**Participant De-Identification Code**

In order to link the responses on your pre-, post-, and 3-month follow-up surveys, we are asking you to create a unique participant de-identification code. This code will be kept in a separate file cabinet from your informed consent and e-mail address, and you will be asked to provide this again for your post- and 3-month follow-up survey. Please write as clearly as possible. To create your unique participant de-identification code, follow the steps below:

1. First letter of your mother’s name?
2. Number of older brothers (living or deceased)?
3. Number representing the month you were born?
4. First letter of your middle name (if none, use X)?

Your unique de-identification code:

(ONLY WRITE THIS CODE ON THE LINE ABOVE, NOTHING ELSE)

**EXAMPLE CODE:**

<table>
<thead>
<tr>
<th>What is the…</th>
<th>Example Answer</th>
<th>Code Element</th>
<th>Full Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>First letter of your mother’s name?</td>
<td>M-Mary</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Number of older brothers (living or deceased)?</td>
<td>01-one</td>
<td>01</td>
<td></td>
</tr>
<tr>
<td>Number representing the month you were born?</td>
<td>05-May</td>
<td>05</td>
<td></td>
</tr>
<tr>
<td>First letter of your middle name (if none, use X)?</td>
<td>A-Ann</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>M0105A</strong></td>
</tr>
</tbody>
</table>
General Questionnaire

• What is your age?
___________________________________________________________________________

• With what gender(s) do you most closely identify? (Choose all that apply)
  □ Male
  □ Female
  □ Transgender
  □ Another gender, please specify: _____________________________________________
  □ Prefer not to answer

• What was the sex listed on your original birth certificate?
  □ Male
  □ Female
  □ Intersex
  □ Another sex, please specify: _______________________________________________
  □ Prefer not to answer

• With what sexual orientation(s) do you most closely identify? (Choose all that apply)
  □ Straight
  □ Gay
  □ Lesbian
  □ Bisexual
  □ Asexual
  □ Another sexual orientation, please specify: _________________________________
  □ Prefer not to answer

• With what race/ethnicity do you most closely identify? (Choose all that apply)
  □ White
  □ Hispanic/Latino(a)
  □ Black or African American
  □ American Indian or Alaska Native
  □ Asian
  □ Native Hawaiian or Pacific Islander
  □ Another race/ethnicity, please specify: _______________________________________
  □ Prefer not to answer
FOR STUDENTS:
(If you are not currently a student, please skip to #12)

- What is the highest level of education you have completed?
  - ☐ High school diploma or equivalent
  - ☐ Associates degree or certificate
  - ☐ Bachelors degree
  - ☐ Masters degree
  - ☐ Doctoral degree (e.g., MD, JD, PhD)
  - ☐ Other, please specify: ____________________

- What is your current field of study?


- What degree are you currently seeking?


- What year are you in your program?


- If you have had a clinical placement(s), in what type of health care setting(s) did you work? (e.g., private practice, primary care clinic, community hospital, FQHC, etc.)


- In what type of health care setting do you aspire to work post-degree?


FOR NON-STUDENTS:

- What is the highest level of education you have completed?

  - ☐ High school diploma or equivalent
  - ☐ Associates degree or certificate
  - ☐ Bachelors degree
  - ☐ Masters degree
  - ☐ Doctoral degree (e.g., MD, JD, PhD)
  - ☐ Other, please specify: ____________________
• In what area of study is your highest degree/certificate?

________________________________________________________________

• In what state did you get your highest degree/certificate?

________________________________________________________________

• What is your current job title?

________________________________________________________________

• How long have you been in your current position?

________________________________________________________________

• In what type of health care setting do you currently work? (e.g., private practice, primary care clinic, community hospital, FQHC, etc.)

________________________________________________________________

• Approximately how many patients do you encounter on a daily basis?

________________________________________________________________

• Overall, how many years have you worked in a health care setting?

________________________________________________________________
Pre-Training Survey

1. Please estimate the total number of transgender patients whom you have worked with in a health care setting.


2. Please estimate the total number of transgender individuals whom you have had contact with outside of health care settings (e.g., family, friends, acquaintances, co-workers, etc.).


3. Approximately what percentage (%) of your current patient panel identifies as transgender (if applicable)?


4. Approximately how many hours of training did you receive in your school curriculum regarding transgender affirmative care?

   □ None  □ 3 – 4 hours  □ 7 – 8 hours  □ > 10 hours
   □ 1 – 2 hours  □ 5 – 6 hours  □ 9 – 10 hours

5. Approximately how many hours of training did you receive in your workplace/assistantship regarding transgender affirmative care?

   □ None  □ 3 – 4 hours  □ 7 – 8 hours  □ > 10 hours
   □ 1 – 2 hours  □ 5 – 6 hours  □ 9 – 10 hours

6. Approximately how many hours of training have you pursued on your own regarding transgender affirmative care?

   □ None  □ 3 – 4 hours  □ 7 – 8 hours  □ > 10 hours
   □ 1 – 2 hours  □ 5 – 6 hours  □ 9 – 10 hours

The next section has a variety of questions that ask you to respond with categories ranging from “strongly disagree” to “strongly agree.” Please note that the term “health care” refers to services provided by individuals working in a health care setting (e.g., physician, mental health professional, technician, physical therapist, speech language pathologist, etc.) and the term “patient” represents the individual receiving care (e.g., client, consumer, etc.). If you have any questions, do not hesitate to ask!
Please carefully read and respond to the following 22 questions. Place an “X” in the box that corresponds with your response.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am educated on transgender identities</td>
<td></td>
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<tr>
<td>2. I know the difference between sex and gender</td>
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<td>3. I am confident in working with transgender patients</td>
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<td>4. I know the difference between cisgender and transgender</td>
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<td>5. I am knowledgeable about routine health care for transgender patients</td>
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<td>6. I am knowledgeable about transition-related care for transgender patients</td>
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<td>7. I understand the challenges transgender patients face in health care settings</td>
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<td>9. I would approach the care for a transgender patient the same as all of my patients</td>
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<td>10. I am comfortable collaborating with other health care providers regarding transgender patients</td>
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<td>11. I do not feel qualified to work with transgender individuals, and thus am likely to refer transgender patients to specialty care</td>
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<td>12. I believe a transgender patient should disclose of their identity to a health care provider right away</td>
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<td>13. I feel confident that I can create a welcoming environment for transgender patients</td>
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<td>14. It would be helpful if a transgender patient could educate me on their health care needs</td>
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<td>15. I would advertise myself as a trans-affirmative provider</td>
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<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Somewhat Disagree</td>
<td>Neutral</td>
<td>Somewhat Agree</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<td>16.</td>
<td>I am comfortable asking about accurate pronouns</td>
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<tr>
<td>17.</td>
<td>I am not familiar with pre- and post-operative care for transgender patients</td>
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<td>18.</td>
<td>I know everything that I need to know about trans-affirmative care</td>
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<tr>
<td>19.</td>
<td>I am aware of the insurance difficulties transgender patients often encounter</td>
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<td>20.</td>
<td>I do not understand a transgender patient’s anatomy</td>
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<tr>
<td>21.</td>
<td>I am familiar with safe sex practices for transgender patients</td>
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<td>22.</td>
<td>I am comfortable adapting my health care to make a transgender patient more comfortable</td>
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</tbody>
</table>
Please carefully read and respond to the remaining 30 questions. Place an “X” in the box that corresponds with your response.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I would feel uncomfortable being in a bathroom with a transgender person.</td>
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<td>2. Being transgender is not a phase.</td>
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<td>3. I would be irritated if someone asked me to use a different name than what they were born with.</td>
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<td>4. Transgender individuals should not be able to use public bathrooms.</td>
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<td>5. Someone who identifies as transgender needs to seek mental health treatment.</td>
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<td>6. Transgender individuals should have equal bathroom rights.</td>
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<td>7. I would have a hard time being friends with a transgender person.</td>
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<tr>
<td>8. Transgender people are like everyone else.</td>
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<td>9. I would feel unsafe being in a locker room with a transgender person.</td>
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<tr>
<td>10. Children should be able to transition in their gender if they express the desire to.</td>
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<tr>
<td>11. Laws should prevent transgender people from choosing what bathroom they want to use.</td>
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<tr>
<td>12. I would be friends with a transgender person.</td>
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<tr>
<td>13. It is my right to know if someone had surgery to change their gender.</td>
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<tr>
<td>14. It would not bother me if a transgender person were in a locker room with me.</td>
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<tr>
<td>15. People who are transgender are deceivers.</td>
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<tr>
<td>16. Being transgender is a choice.</td>
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</tbody>
</table>

113
<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>17. Transgender individuals deserve privacy regarding their personal transition.</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Somewhat Disagree</td>
<td>Neutral</td>
<td>Somewhat Agree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>18. I would be irritated if someone asked me to use different pronouns when talking about them.</td>
<td></td>
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<tr>
<td>19. A person’s genitals does not determine what bathroom they should use.</td>
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<tr>
<td>20. I feel uncomfortable if I cannot tell if someone is a man or woman.</td>
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<td>21. I would be proud to know someone who is transgender.</td>
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<tr>
<td>22. I would be uncomfortable learning about a transgender person’s surgery.</td>
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<td>23. Transgender people have mental disorders.</td>
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<td>24. Children should be encouraged to explore gender roles that they feel comfortable in.</td>
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<td>25. Transgender people should be obligated to tell people that they are transgender.</td>
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<td>26. I can usually tell when someone is transgender.</td>
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<td>27. It is important to talk about transgender issues.</td>
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<td>28. I would never be romantically involved with a transgender person.</td>
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<td>29. I would not feel comfortable using the word “transgender” in an everyday conversation.</td>
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<td>30. If a friend wanted to have surgery to change their gender, I would support them.</td>
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</tbody>
</table>
THE RESEARCH ASSISTANT WILL PICK
UP YOUR PRE-TRAINING SURVEY
MATERIALS
Appendix F

Transgender-Affirmative Care Post-Training Survey Packet

TRANSGENDER-AFFIRMATIVE CARE: POST-TRAINING MATERIALS
Participant De-Identification Code

In order to link the responses from your pre-survey to your post- and 3-month follow-up surveys, we are asking you to provide your unique participant de-identification code once again. Please write it below as clearly as possible.

1. First letter of your mother’s name?
2. Number of older brothers (living or deceased)?
3. Number representing the month you were born?
4. First letter of your middle name (if none, use X)?

Your unique de-identification code:

(ONLY WRITE THIS CODE ON THE LINE ABOVE, NOTHING ELSE)

EXAMPLE CODE:

<table>
<thead>
<tr>
<th>What is the…</th>
<th>Example Answer</th>
<th>Code Element</th>
<th>Full Code</th>
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<td>First letter of your mother’s name?</td>
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<td>M</td>
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<tr>
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<td>05-May</td>
<td>05</td>
<td></td>
</tr>
<tr>
<td>First letter of your middle name (if none, use X)?</td>
<td>A-Ann</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

M0105A
Please carefully read and respond to the following 22 questions. Place an “X” in the box that corresponds with your response.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Agree</th>
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<tbody>
<tr>
<td>1. I am educated on transgender identities</td>
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<td>2. I know the difference between sex and gender</td>
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<td>4. I know the difference between cisgender and transgender</td>
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<td>9. I would approach the care for a transgender patient the same as all of my patients</td>
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<td>19. A person’s genitals does not determine what bathroom they should use.</td>
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<td>20. I feel uncomfortable if I cannot tell if someone is a man or woman.</td>
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<td>24. Children should be encouraged to explore gender roles that they feel comfortable in.</td>
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<td>26. I can usually tell when someone is transgender.</td>
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<td>27. It is important to talk about transgender issues.</td>
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<td>28. I would never be romantically involved with a transgender person.</td>
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<td>29. I would not feel comfortable using the word “transgender” in an everyday conversation.</td>
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<td>30. If a friend wanted to have surgery to change their gender, I would support them.</td>
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</table>
Please carefully read and respond to the final questions. Circle the response that corresponds with your response. Feel free to elaborate upon your response in the space below each question.

<table>
<thead>
<tr>
<th>I feel that attending this training will make a <strong>difference</strong> in the way I do my job</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
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<table>
<thead>
<tr>
<th>This training has increased my <strong>knowledge</strong> on how to work with transgender patients</th>
<th>Strongly Disagree</th>
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<tr>
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<tr>
<th>I feel less likely to refer out as a result of my training on trans-affirmative care</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>It is important that this training is delivered by a transgender individual</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
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<td>Somewhat Agree</td>
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<td>What aspect(s) of the training were most helpful?</td>
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<td>What are some suggestions you have to improve the training?</td>
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<td>Thank you for participating! You will receive an e-mail in 3 months with a link to a brief follow-up survey. Your time is greatly appreciated!</td>
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Appendix G

Transgender-Affirmative Care 3-Month Follow-Up Qualtrics Survey

You are invited to participate in the 3-month follow-up survey following the training on *Transgender-Affirmative Care: Understanding and Overcoming Barriers to Care for Transgender Patients*.

As a reminder, the overall purpose of this study is to investigate the impact a transgender-affirmative care training may have on health workers’ attitude toward and knowledge of routine care and transition support for transgender individuals. This online survey should take about 10 – 15 minutes to complete. Participation is voluntary, and responses will be kept anonymous to the degree permitted by the technology being used.

You have the option to not respond to any questions that you choose. Participation or non-participation will not impact your relationship with the University of Montana.

If you have any questions about the research, please contact the Principal Investigator, Oakleigh Reed, via email at oakleigh.reed@umontana.edu or the faculty advisor, Dr. Bryan Cochran at bryan.cochran@umontana.edu. You have any questions regarding your rights as a research subject, contact the UM Institutional Review Board (IRB) at (406) 243-6672.

Please print or save a copy of this page for your records.

☐ Click here to enter survey
In order to link your pre- and post-training responses, please enter your unique de-identification code below:

1. First letter of your mother’s name?
2. Number of older brothers (living or deceased)?
3. Number representing the month you were born?
4. First letter of your middle name (if none, use X)?

Please type your unique de-identification code below:

_____________________________________________________________________________

<table>
<thead>
<tr>
<th>What is the…</th>
<th>Example Answer</th>
<th>Code Element</th>
<th>Full Code</th>
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<tbody>
<tr>
<td>First letter of your mother’s name?</td>
<td>M-Mary</td>
<td>M</td>
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<tr>
<td>Number of older brothers…</td>
<td>01-one</td>
<td>01</td>
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<td>Number representing the month you…</td>
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<tr>
<td>First letter of your middle name…</td>
<td>A-Ann</td>
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M0105A
Please carefully read and respond to the following 22 questions. Click the choice that corresponds with your response.

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<th>Question</th>
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<tbody>
<tr>
<td>1. I am educated on transgender identities</td>
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<td>2. I know the difference between sex and gender</td>
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<td>4. I know the difference between cisgender and transgender</td>
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<td>5. I am knowledgeable about routine health care for transgender patients</td>
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<td>6. I am knowledgeable about transition-related care for transgender patients</td>
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<td>7. I understand the challenges transgender patients face in health care settings</td>
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<td>8. I feel better trained than my colleagues on trans-affirmative care</td>
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<td>9. I would approach the care for a transgender patient the same as all of my patients</td>
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<td>10. I am comfortable collaborating with other health care providers regarding transgender patients</td>
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<td>11. I do not feel qualified to work with transgender individuals, and thus am likely to refer transgender patients to specialty care</td>
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| 3. I would be irritated if someone asked me to use a different name than what they were born with. |
| 4. Transgender individuals should not be able to use public bathrooms. |
| 5. Someone who identifies as transgender needs to seek mental health treatment. |
| 6. Transgender individuals should have equal bathroom rights. |
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<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Somewhat Disagree</td>
<td>Neutral</td>
<td>Somewhat Agree</td>
<td>Agree</td>
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<tr>
<td>17.</td>
<td>Transgender individuals deserve privacy regarding their personal transition.</td>
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<tr>
<td>18.</td>
<td>I would be irritated if someone asked me to use different pronouns when talking about them.</td>
<td></td>
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<tr>
<td>19.</td>
<td>A person’s genitals does not determine what bathroom they should use.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20.</td>
<td>I feel uncomfortable if I cannot tell if someone is a man or woman.</td>
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<tr>
<td>21.</td>
<td>I would be proud to know someone who is transgender.</td>
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<tr>
<td>22.</td>
<td>I would be uncomfortable learning about a transgender person’s surgery.</td>
<td></td>
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</tr>
<tr>
<td>23.</td>
<td>Transgender people have mental disorders.</td>
<td></td>
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<tr>
<td>24.</td>
<td>Children should be encouraged to explore gender roles that they feel comfortable in.</td>
<td></td>
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<tr>
<td>25.</td>
<td>Transgender people should be obligated to tell people that they are transgender.</td>
<td></td>
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<tr>
<td>26.</td>
<td>I can usually tell when someone is transgender.</td>
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<tr>
<td>27.</td>
<td>It is important to talk about transgender issues.</td>
<td></td>
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<tr>
<td>28.</td>
<td>I would never be romantically involved with a transgender person.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>29.</td>
<td>I would not feel comfortable using the word “transgender” in an everyday conversation.</td>
<td></td>
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<tr>
<td>30.</td>
<td>If a friend wanted to have surgery to change their gender, I would support them.</td>
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Please carefully read and respond to the final questions. Click the choice that corresponds with your response. Feel free to elaborate upon your response in the space below.

<table>
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<tr>
<th>I feel that attending the training has made a <strong>difference</strong> in the way I do my job</th>
<th><strong>Strongly Disagree</strong></th>
<th><strong>Disagree</strong></th>
<th><strong>Somewhat Disagree</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Somewhat Agree</strong></th>
<th><strong>Agree</strong></th>
<th><strong>Strongly Agree</strong></th>
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<tr>
<td>Please elaborate:</td>
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<td></td>
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<table>
<thead>
<tr>
<th>The training increased my <strong>knowledge</strong> on how to work with transgender patients</th>
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<th><strong>Neutral</strong></th>
<th><strong>Somewhat Agree</strong></th>
<th><strong>Agree</strong></th>
<th><strong>Strongly Agree</strong></th>
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<tbody>
<tr>
<td>Please elaborate:</td>
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</table>

<table>
<thead>
<tr>
<th>The training increased my <strong>confidence</strong> in working with transgender patients</th>
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<th><strong>Disagree</strong></th>
<th><strong>Somewhat Disagree</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Somewhat Agree</strong></th>
<th><strong>Agree</strong></th>
<th><strong>Strongly Agree</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please elaborate:</td>
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</table>

<table>
<thead>
<tr>
<th>I feel less likely to refer out as a result of my training on trans-affirmative care</th>
<th><strong>Strongly Disagree</strong></th>
<th><strong>Disagree</strong></th>
<th><strong>Somewhat Disagree</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Somewhat Agree</strong></th>
<th><strong>Agree</strong></th>
<th><strong>Strongly Agree</strong></th>
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</table>

<table>
<thead>
<tr>
<th>I have seen new transgender patients since the training</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have changed my approach to health care since the training</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have sought out additional information regarding trans-affirmative care since the training</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have consulted more with colleagues or had rich conversations regarding trans-affirmative care since the training</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have helped educate my colleagues on trans-affirmative care since the training</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have incorporated some of the changes that were suggested in the training (e.g., locating gender-neutral bathrooms, checking intake paperwork, etc.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>What from that training have you incorporated into your practice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your continued participation, your time is greatly appreciated!
Appendix H

Transgender-Affirmative Care Training Curriculum

Transgender-Affirmative Care

Identifying & Overcoming Barriers to Care for Transgender Patients

Oak Reed, M.A.
Doctoral Candidate in Clinical Psychology

Training Location
Date

TALKING POINTS:
- Introduce training
TALKING POINTS:
- Introduce self and relevant background information
**Who is a trans-affirmative provider?**

*Educated* on transgender identities  
*Aware* of barriers to care  
*Conscientious* of creating a welcoming environment  
*Advocates* for excellent physical and mental health services  
*Collaborates* with an interdisciplinary team to achieve holistic care

**TALKING POINTS:**  
- Overview the key characteristics to being a trans-affirmative provider  
- Emphasize that this is a role that is constantly evolving, and that continued education is key to staying competent
General Outline

• Touch on important terminology

• Overview contemporary statistics regarding:
  • Onset of gender identity
  • Common barriers to care
  • Health disparities

• Discuss strategies on how to create a welcoming environment

• Provide recommendations for best practices for institutions and health care providers

• Answer questions at any point!

TALKING POINTS:
- Overview the overall flow of the presentation
- Remember to invite questions throughout
Learning Objectives

• 1) Describe demographics and define appropriate terminology
• 2) Identify and describe the health disparities that transgender populations face
• 3) Characterize the unique primary care needs of transgender patients
• 4) Identify transgender-specific factors that influence the populations’ access to
   and experiences with the US healthcare system, including quality of care and the
   patient–provider relationship
• 5) Name support services available to transgender patients
• 6) Identify sources of quality information on the care of transgender patients
• 7) Describe ongoing and upcoming research questions in transgender healthcare

**TALKING POINTS:**
- Overview the goals/outcomes of the presentation
- Emphasize what individuals should know walking away from the presentation

TALKING POINTS:
-Sex = assigned at birth; internal/external genitalia, chromosomal, hormonal
-Gender = identity; cultural, social, idiographic
-Sexuality = multifaceted – addressed in another slide
TALKING POINTS:
- A transgender identity is when an individual’s sex assigned at birth does not match with their current gender identity
- This identity is fluid and expands beyond the gender binary
TALKING POINTS:
- A cisgender identity is when an individual’s sex assigned at birth does match with their current gender identity
- This identity is within the gender binary of male and female
**TALKING POINTS:**

- Sexual orientation multifaceted, and one does not dictate another
- Sexual identity = an individual’s self identification with labels they prefer
- Sexual behavior = who an individual engages in sexual intercourse/behavior with
- Sexual attraction = who an individual is attracted to
TALKING POINTS:
- Gender identity development is similar to any typically developing child
- Population estimates of the transgender community are likely a product of the under- or nonrepresentation of transgender individuals in population surveys
  --This acts as a major barrier to understanding social determinants and health disparities

RESOURCE(S):
UNDERSTANDING BARRIERS TO CARE

TALKING POINTS:
- Emphasize that barriers to care feel overwhelming to transgender individuals
TALKING POINTS:
- No explicit state protections for discrimination based on gender identity in 27 states as of October, 2018
- MAP updates their statistics periodically, and maps can be found for each individual state

RESOURCE(S):
TALKING POINTS:
- Previous report 2008-2009 data collection – published 2011 (6,450 respondents; current is over 4 times the amount from this survey)
- Future report 2020

TALKING POINTS:
- Access to health care is a fundamental human right that is regularly denied to transgender and gender non-conforming people.
- Barriers to care: seeking preventive medicine, routine and emergency care, or transgender-related services.

- Access to care:
  19% = no health insurance (17% G.P.); 51% = employer-based coverage (58% G.P.)

- Postponed care:
  28% fear of discrimination; 48% inability to afford

- Refusal of care:
  19% were refused care based on gender identity; Increases with intersectional identities (e.g., minority race, sexuality)

- Uninformed care provider:
  50% have to teach their health care providers about transgender care

TALKING POINTS:
-Highlight the unique aspect of the qualitative responses the USTS has that gives a voice to the transgender community

TALKING POINTS:
- 22% of respondents rated their health as “fair” or “poor,” compared with 18% of the U.S. population.
- 39% of respondents were currently experiencing serious psychological distress, nearly eight times the rate in the U.S. population (5%).
- 40% have attempted suicide in their lifetime, nearly nine times the rate in the U.S. population (4.6%).
- 7% attempted suicide in the past year—nearly twelve times the rate in the U.S. population (0.6%).

-Lost a job due to bias (55%)
-Harassed/bullied in school (51%)
-Victim of physical assault (61%) or sexual assault (64%)
-Other studies state that the suicide rate 25 times the prevalence in the general population at the low end, and 40 times at the high end
--This Increases w/ intersectionality of minority identities

"I was told that I was deceiving my doctor and interfering with my care by not disclosing identifying as transgender right away, despite my presenting concern being vertigo."

TALKING POINTS
- Disclose of personal experiences in health care settings, and share how one affirmative provider can make a felt impact
TALKING POINTS:
1) Prejudice, discrimination, and stigma has long permeated into our thoughts/beliefs/opinions regarding transgender individuals
   -A lot of this is a product of misinformation, fear, and oppression
2) As a result of experience high amounts of prejudice and discrimination, transgender individual often avoid places that they may need to access in order to maintain their health and well-being
   -For example, avoiding health care institutions, places of employment, bathrooms/locker rooms
3) The avoidance of such places leads to health disparities, for if transgender individuals are not caring for their basic needs (e.g., food, shelter, water, health), they are at a higher rate for physical, mental, and social disparities
4) This cycle continues to feed into itself, as higher rates of physical, mental, and social disparities often leads to higher rates of prejudice, discrimination, and stigma
TALKING POINTS:
-Give examples of how different types of health care providers may be able to help
--E.g., administrative staff does the initial intakes, chaplains may discuss religious
beliefs/hesitations regarding transitioning, SLPs may help with vocal coaching, etc.
TALKING POINTS:
- Emphasize that creating a welcoming environment makes the barriers to care feel less overwhelming, and facilitates more approach rather than avoidance.
Questions?

“Health care providers know 90% – 100% of what they need to know for the health care of trans folks”
-Dr. Joey Banks

TALKING POINTS:
-Remind the audience that this is not specialty care, and that it is not “rocket science”
TALKING POINTS:
- Introduce how an individual can make a difference on their own
**TALKING POINTS:**
- Assuming can lead to oversights and microaggressions
- Provide several examples and ask for others
- Remind participants that someone’s gender identity may be identified at different stages of life, and that they may never have “looked” like their sex assigned at birth
TALKING POINTS:
- Body language can go a long way, and constantly scanning a patient or acting/looking stressed when a person’s gender identity is not clear can damage rapport.
TALKING POINTS:
- Current gender identity and legal sex may not match – do not just consult one document
- Many states do not have the ability to change gender marker, or have strict limitations
  -- Others have a third-gender “X” option
- This is an ongoing question – don’t just ask and document once, get frequent updates
- Become comfortable with using gender neutral pronouns or asking for accurate pronouns
**TALKING POINTS:**
- Emphasize to ask, ask, ask!

**Individual Strategies**

If you are unsure about a patient’s name or pronoun

- What name do you prefer?
- What pronouns do you identify with?

**Addressing Patients**

If a patient’s name doesn’t match insurance or medical records

- Could your chart/insurance be under a different name?
- What name does your insurance have you listed as?

If you make a mistake

- Don’t sweat it! Take note and affirm the patient next time.

**Addressing Patients**

- If you make a mistake, don’t sweat it! Take note and affirm the patient next time.

- If a patient’s name doesn’t match insurance or medical records, be open to understanding their preferred name.

- When unsure about a patient’s name or pronoun, ask directly and respectfully.

- Emphasize the importance of asking multiple times to ensure accuracy and respect for the patient’s identity.

- Always address patients by their preferred name and pronouns to maintain their dignity and comfort.

- Be prepared to correct mistakes and learn from them to improve communication skills.

- In cases where a patient’s name or pronoun cannot be confirmed, it’s crucial to approach the situation with empathy and a willingness to adapt as needed.
TALKING POINTS:
-Mention that there are ways to modify clinical records, and that partnering with IT can be beneficial
TALKING POINTS:
- Address the fact that current anatomy may be uncomfortable to discuss, and that using affirmative language can make or break the comfort level for transgender patients
- Reflect on how inclusive paperwork at intake can avoid awkward mistakes
- Recommend to consult best practice guidelines for addressing routine care based on current anatomy
TALKING POINTS:
- Remind participants that this approach to care is not difficult, but that it may be new for many individuals.
TALKING POINTS:
- Introduce how an organization can make differences collectively through policy change and protocols
TALKING POINTS:
- Consider transforming single-stall gendered bathrooms to be gender neutral; if there are gender neutral bathrooms in the organization, know where they are located
- Review paperwork and see if it is inclusive and does not restrict patients to closed-ended questions
- Consult with IT to make sure that EHRs accurately represent the current identity of a patient
- Read through the non-discrimination policy and be familiar with what it includes/excludes; if it is not comprehensive, consider discussing the shortcomings with management
- Have LGBT décor visible in the space to create a welcoming environment
- Have all new employees go through some sort of “safe zone” training and make this ongoing to employees as well
TALKING POINTS:
-Briefly touch on procedures that transgender patients may be seeking
TALKING POINTS:
- Remind everyone to collaborate with their colleagues to improve the overall health care of transgender patients
TALKING POINTS:
- This slide was added for the virtual trainings to direct them back to Qualtrics in order to complete the post-training survey

Please exit out of the video tab and return to the original tab to complete the post-training survey!

Returning to this survey and completing the last few questions is critical for the research component of this overall project. Thank you in advance!

If you for whatever reason lose access to the post-training survey, please e-mail the principal investigator at oakleigh.reed@umontana.edu
TALKING POINTS:
- Encourage the participants to e-mail with any follow-up questions

Questions?
Thank you!
oakleigh.reed@umontana.edu
TALKING POINTS:
-Offer access to any personal research participants may be interested in
TALKING POINTS:
- Offer access to any personal research participants may be interested in
Helpful Materials

- State Specific:
  - X
  - Y
  - Z
- Adult Transgender Care: An Interdisciplinary Approach to Training Mental Health Professionals Transgender Law Center
- The Fenway Institute
  - https://dossiertoell.org/ehr/toolkit/
- Joint Commission
  - https://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf
- National Center for Transgender Equality
- National LGBT Health Education Center
- Endocrine Society

TALKING POINTS:
-Mention that there are plenty local and national resources to additional consult and be familiar with
References


Appendix I

YouTube Video Link

https://www.youtube.com/watch?v=hCb7I1rDnYg&t=315s
### Table 1.1
Demographic Characteristics of Sample: Study 1

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<th>Range</th>
<th>M</th>
<th>SD</th>
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</table>

**Note:** N = 151. Fields of study for students include: pharmacy, pharmaceutical science, and pharmacology, with 11 participants pursuing a dual degree in pharmacy paired with business, business administration, or public health. Fields of study for professionals include: pharmacy and education. The current job title these healthcare workers identified as holding were: Assistant Dean, Associate Professor, and Clinical Pharmacist.
### Table 1.2
Demographic Characteristics of Sample: Study 2

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>M</th>
<th>SD</th>
<th>N</th>
<th>%</th>
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<tbody>
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<td>116</td>
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<tr>
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<tr>
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<td>21</td>
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<td>Another gender</td>
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<td></td>
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<tr>
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<td>0.7</td>
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<tr>
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<td><strong>Race / Ethnicity</strong></td>
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<td>Hispanic Latino(a)</td>
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<td>American Indian or Alaska Native</td>
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<td></td>
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<tr>
<td>Asian</td>
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<td></td>
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<td>Black or African American</td>
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<td></td>
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<tr>
<td>Another race / ethnicity</td>
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<tr>
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<td>1.4</td>
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<td><strong>Education Level</strong></td>
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<tr>
<td>Associate degree or certificate</td>
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<td>4.3</td>
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<tr>
<td>Bachelor’s degree</td>
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<td>Master’s degree</td>
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<td>Doctoral degree (e.g., MD, JD, PhD)</td>
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<td>18.1</td>
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<tr>
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<tr>
<td><strong>Professional Status</strong></td>
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<td>Student</td>
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<td>Year in program</td>
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</tr>
<tr>
<td>Years in health care setting</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Work Setting**

|                  |       |      |     |    |     |
| Urban            | 71    | 51.4 |     |    |     |
| Rural            | 45    | 32.6 |     |    |     |
| Unsure           | 21    | 15.2 |     |    |     |
| No response      | 1     | 0.7  |     |    |     |
Note: N = 138. Fields of study for students include: biostatistics, psychology (clinical, counseling, health), nursing, pediatric endocrinology, pharmacy, physical therapy, and social work, with 2 participants pursuing a dual degree in one of the above mentioned with business administration or public health. Fields of study for professionals include: allied health science, anthropology and Native American studies, biology, biomedical engineering, business, business management, chemistry, clinical neuropsychology, clinical psychology, counseling, counselor education, criminal justice, dietetics, medicine (MD, DO), early childhood education, English literature, environmental science, health science, history, journalism, mental health counseling, nursing, nurse practitioner, physical therapy, physician assistant, professional zoology, public health, public administration, rehabilitation psychology, social work, sociology, Spanish, speech-language pathology, and women’s health. The current job title these healthcare workers identified as holding were: AASECT Certified Sexuality Educator, Administrative Support, Assistant Care Team Coordinator, Assistant Professor, Behavioral Health Social Worker, Care Advocate, Chief of Psychology, Clinical Psychologist, Clinical Chemistry Fellow, Chief Medical Officer of Planned Parenthood (state omitted), Community Health Nurse, Community Health Worker, Community School Coordinator, Coordinator/Program Manager, Counselor, Director of Behavioral Medicine, Division Chair, Environmental Health Clerk, Environmental Health Specialist, Environmental Health Technician, Executive Director of Counseling Services, Family Medicine Physician, Health Educator, Hearing and Vision, Housing Navigator, Immunization Supervisor, Intake/Receptionist, Licensed Clinical Professional Counselor, Marketing Director, Master’s Level Clinician, Medical Doctor, Mental Health Peer Support Worker, Mental Health Professional Clerk, Neuropsychologist, Neuropsychology Fellow, Neuropsychology Technician/Psychometrist, Nurse, Nurse Practitioner, Office Assistant, Onboarding Coordinator, Parent Support Partner, Patient Service Representative, Pediatric Psychologist, Physician Assistant, Professor, Psychologist, Public Health Nurse, Public Health Social Worker, Registered Dietitian, Registered Nurse Clinical Educator, Sanitarian, Senior Patient Service Representative, Social Worker, Speech-Language Pathologist, Supervisor, Supports Coordinator Assistant, Technical Support Clerk, Therapist, Therapy Manager, Women’s Health Nurse Practitioner, Youth Manager, and Youth Peer Supervisor.
### Table 2.1

**Descriptive Statistics of Contact: Study 1**

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional Contact</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0-50</td>
<td>84</td>
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<tr>
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<td>67</td>
<td>44.4</td>
</tr>
<tr>
<td><strong>Personal Contact</strong></td>
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<td></td>
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<td>103</td>
<td>68.2</td>
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<tr>
<td>No</td>
<td></td>
<td>48</td>
<td>31.8</td>
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<tr>
<td><strong>Prior Training in Transgender Health:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>School Curriculum</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 hours</td>
<td></td>
<td>129</td>
<td>85.4</td>
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<tr>
<td>1-2 hours</td>
<td></td>
<td>22</td>
<td>14.6</td>
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<tr>
<td><em>Workplace/Assistantship</em></td>
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<td></td>
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<tr>
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<td>125</td>
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<td>21</td>
<td>13.9</td>
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<td>3-4 hours</td>
<td></td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>5-6 hours</td>
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<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td><em>On One's Own</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 hours</td>
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<td>111</td>
<td>73.5</td>
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<td>12</td>
<td>7.9</td>
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<td>7-8 hours</td>
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<td>1.3</td>
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</table>

*Note: Contact refers to interactions with a transgender individual or materials that depict and/or describe transgender identities and/or experiences. Ranges reported for professional and personal contact are based upon self-report estimates (i.e., “Please estimate the total number of transgender patients whom you have worked with in a health care setting” and “Please estimate the total number of transgender individuals whom you have had contact with outside of health care settings (e.g., family, friends, acquaintances, co-workers, etc.). The professional and personal contact variables were recoded to “yes” for those who reported one or more contact experiences and “no” for those who did not report any contact.*
Table 2.2
Descriptive Statistics of Contact: Study 2

<table>
<thead>
<tr>
<th>Professional Contact</th>
<th>Range</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
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<tr>
<td>Yes</td>
<td>0-70</td>
<td>90</td>
<td>65.2</td>
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<tr>
<td>No</td>
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<td>48</td>
<td>34.8</td>
</tr>
<tr>
<td>Personal Contact</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>107</td>
<td>77.5</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>31</td>
<td>22.5</td>
</tr>
</tbody>
</table>

Prior Training in Transgender Health:
School Curriculum

<table>
<thead>
<tr>
<th>Hours</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>83</td>
<td>60.1</td>
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<td>1-2</td>
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<td>24.6</td>
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<td>11.6</td>
</tr>
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<td>5-6</td>
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<td>1.4</td>
</tr>
<tr>
<td>7-8</td>
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<td>1.4</td>
</tr>
<tr>
<td>9-10</td>
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<td>0.7</td>
</tr>
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</table>

Workplace/Assistantship

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<th>Hours</th>
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</thead>
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<td>1-2</td>
<td>32</td>
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<tr>
<td>3-4</td>
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<td>2.9</td>
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<tr>
<td>&gt;10</td>
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<td>4.3</td>
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</table>

On One's Own

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<th>Hours</th>
<th>N</th>
<th>%</th>
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<td>0</td>
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<tr>
<td>&gt;10</td>
<td>15</td>
<td>10.9</td>
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</table>

Note: Contact refers to interactions with a transgender individual or materials that depict and/or describe transgender identities and/or experiences. Ranges reported for professional and personal contact are based upon self-report estimates (i.e., “Please estimate the total number of transgender patients whom you have worked with in a health care setting” and “Please estimate the total number of transgender individuals whom you have had contact with outside of health care settings (e.g., family, friends, acquaintances, co-workers, etc.). The professional and personal contact variables were recoded to “yes” for those who reported one or more contact experiences and “no” for those who did not report any contact.
Table 3.1
Average Scores, Ranges, and Standard Deviations for Measure of Knowledge/Awareness:
Study 1

<table>
<thead>
<tr>
<th>Measure of Transgender Topics Measure</th>
<th>N</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Training Survey ($T_1$)</td>
<td>151</td>
<td>2.27-5.39</td>
<td>3.95</td>
<td>0.67</td>
</tr>
<tr>
<td>Post-Training Survey ($T_2$)</td>
<td>151</td>
<td>3.68-6.18</td>
<td>5.08</td>
<td>0.51</td>
</tr>
<tr>
<td>3-Month Follow-Up Survey ($T_3$)</td>
<td>48</td>
<td>3.45-6.05</td>
<td>4.88</td>
<td>0.53</td>
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</tbody>
</table>

Note: Quantitative scores were computed by calculating participants’ average response across all 22 items on the Likert scale (1 = “strongly disagree,” 7 = “strongly agree”), with consideration of six reverse coded items (e.g., numbers 9, 11, 12, 14, 17, 20). Higher average ratings on the ATTM indicate higher levels of knowledge/awareness of transgender topics. The range represents the varying amount of knowledge/awareness participants indicated for each measure, and the mean and standard deviation represent the average amount of knowledge/awareness and the associated average deviation from the mean for each measurement.
Table 3.2
Average Scores, Ranges, and Standard Deviations for Measure of Knowledge/Awareness: Study 2

<table>
<thead>
<tr>
<th>Awareness of Transgender Topics Measure</th>
<th>N</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Training Survey (T₁)</td>
<td>138</td>
<td>2.32-6.14</td>
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<td>0.79</td>
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<tr>
<td>Post-Training Survey (T₂)</td>
<td>138</td>
<td>3.59-6.50</td>
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<td>0.53</td>
</tr>
<tr>
<td>3-Month Follow-Up Survey (T₃)</td>
<td>48</td>
<td>4.09-6.14</td>
<td>5.33</td>
<td>0.50</td>
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</table>

Note: Quantitative scores were computed by calculating participants’ average response across all 22 items on the Likert scale (1 = “strongly disagree,” 7 = “strongly agree”), with consideration of six reverse coded items (e.g., numbers 9, 11, 12, 14, 17, 20). Higher average ratings on the ATTM indicate higher levels of knowledge/awareness of transgender topics. The range represents the varying amount of knowledge/awareness participants indicated for each measure, and the mean and standard deviation represent the average amount of knowledge/awareness and the associated average deviation from the mean for each measurement.
Table 4.1
Average Scores, Ranges, and Standard Deviations for Measure of Prejudice: Study 1

<table>
<thead>
<tr>
<th>Anti-Transgender Prejudice Scale</th>
<th>N</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Training Survey (T1)</td>
<td>151</td>
<td>1.07-6.37</td>
<td>2.65</td>
<td>0.94</td>
</tr>
<tr>
<td>Post-Training Survey (T2)</td>
<td>151</td>
<td>1.10-6.27</td>
<td>2.44</td>
<td>0.94</td>
</tr>
<tr>
<td>3-Month Follow-Up Survey (T3)</td>
<td>48</td>
<td>1.10-6.13</td>
<td>2.31</td>
<td>0.94</td>
</tr>
</tbody>
</table>

Note: Quantitative scores were computed by calculating participants’ average response across all 30 items on the Likert scale (1 = “strongly disagree,” 7 = “strongly agree”), with consideration of twelve reverse coded items (e.g., numbers 2, 6, 8, 10, 12, 14, 17, 19, 21, 24, 27, 30). Higher average ratings on the ATPS indicate higher levels anti-transgender prejudice. The range represents the varying amount of prejudice participants indicated for each measure, and the mean and standard deviation represent the average amount of prejudice and the associated average deviation from the mean for each measurement.
Table 4.2
Average Scores, Ranges, and Standard Deviations for Measure of Prejudice: Study 2

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Range</th>
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</thead>
<tbody>
<tr>
<td><strong>Anti-Transgender Prejudice Scale</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Training Survey ($T_1$)</td>
<td>138</td>
<td>1.03-4.30</td>
<td>2.00</td>
<td>0.72</td>
</tr>
<tr>
<td>Post-Training Survey ($T_2$)</td>
<td>138</td>
<td>1.00-4.07</td>
<td>1.80</td>
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<tr>
<td>3-Month Follow-Up Survey ($T_3$)</td>
<td>48</td>
<td>0.97-3.73</td>
<td>1.72</td>
<td>0.63</td>
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</tbody>
</table>

Note: Quantitative scores were computed by calculating participants’ average response across all 30 items on the Likert scale (1 = “strongly disagree,” 7 = “strongly agree”), with consideration of twelve reverse coded items (e.g., numbers 2, 6, 8, 10, 12, 14, 17, 19, 21, 24, 27, 30). Higher average ratings on the ATPS indicate higher levels anti-transgender prejudice. The range represents the varying amount of prejudice participants indicated for each measure, and the mean and standard deviation represent the average amount of prejudice and the associated average deviation from the mean for each measurement.
Table 5.1

Summary of Independent Samples t-tests of Contact by Anti-Transgender Prejudice: Study 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Contact</th>
<th>M(SD)</th>
<th>M(SD)</th>
<th>F</th>
<th>t(df)</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td>ATPS</td>
<td>Yes</td>
<td>2.6 (0.91)</td>
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<td>0.88</td>
<td>1.27 (149)</td>
<td>0.21</td>
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<tr>
<td>ATPS</td>
<td>No</td>
<td>2.84 (1.05)</td>
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</tbody>
</table>

Note: df = 149; *p < .05. **p < .01. ***p < .001.
Table 5.2

Summary of Independent Samples t-tests of Contact by Anti-Transgender Prejudice: Study 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Yes</th>
<th>No</th>
<th>F</th>
<th>t(df)</th>
<th>p</th>
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</thead>
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<tr>
<td></td>
<td>M(SD)</td>
<td>M(SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATPS</td>
<td>1.96 (0.70)</td>
<td>2.32 (0.82)</td>
<td>0.80</td>
<td>2.0(136)</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Note: df = 136; *p < .05. **p < .01. ***p < .001.
Table 6.1

*Summary of Paired Samples t-tests of Test Variables by Pre- & Immediate Post-Training Measurements: Study 1*

<table>
<thead>
<tr>
<th>Variables</th>
<th>(T_1) M(SD)</th>
<th>(T_2) M(SD)</th>
<th>(M_{DIFF})</th>
<th>(t(df)) (d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATPS</td>
<td>2.65 (0.94)</td>
<td>2.44 (0.94)</td>
<td>-0.21</td>
<td>-8.45(150)**</td>
</tr>
<tr>
<td>ATTM</td>
<td>3.95 (0.67)</td>
<td>5.08 (0.51)</td>
<td>1.12</td>
<td>26.2(150)**</td>
</tr>
</tbody>
</table>

*Note: df = 150; * \(p < .05\). ** \(p < .01\). *** \(p < .001\).*
Table 6.2  
*Summary of Paired Samples t-tests of Test Variables by Pre- & Immediate Post-Training Measurements: Study 2*

<table>
<thead>
<tr>
<th>Variables</th>
<th>T1</th>
<th>T2</th>
<th>MDIFF</th>
<th>t(df)</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATPS</td>
<td>2.00 (0.72)</td>
<td>1.80 (0.65)</td>
<td>-0.20</td>
<td>-8.04(137)***</td>
<td>0.29</td>
</tr>
<tr>
<td>ATTM</td>
<td>4.34 (0.67)</td>
<td>5.35 (0.45)</td>
<td>1.01</td>
<td>20.54(137)***</td>
<td>1.77</td>
</tr>
</tbody>
</table>

*Note: df = 137; *p < .05. **p < .01. ***p < .001.*
Table 7.1
Summary of Paired Samples t-tests of Test Variables by Immediate Post- & 3-Month Post-Training Measurements: Study 1

<table>
<thead>
<tr>
<th>Variables</th>
<th>T₂ M(SD)</th>
<th>T₃ M(SD)</th>
<th>MDIFF</th>
<th>t(df)</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATPS</td>
<td>2.06 (0.96)</td>
<td>2.31 (0.94)</td>
<td>0.25</td>
<td>4.28(47)***</td>
<td>0.26</td>
</tr>
<tr>
<td>ATTM</td>
<td>5.2 (0.49)</td>
<td>4.88 (0.53)</td>
<td>-0.31</td>
<td>-5.69(47)***</td>
<td>0.61</td>
</tr>
</tbody>
</table>

Note: df = 47; *p < .05. **p < .01. ***p < .001.
Table 7.2
Summary of Paired Samples t-tests of Test Variables by Immediate Post- & 3-Month Post-
Training Measurements: Study 2

<table>
<thead>
<tr>
<th>Variables</th>
<th>T2 (M(SD))</th>
<th>T3 (M(SD))</th>
<th>(M_{DIFF})</th>
<th>(t(df))</th>
<th>(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATPS</td>
<td>1.67 (0.58)</td>
<td>1.72 (0.63)</td>
<td>0.05</td>
<td>1.34(47)</td>
<td>0.08</td>
</tr>
<tr>
<td>ATTM</td>
<td>5.56 (0.46)</td>
<td>5.33 (0.50)</td>
<td>-0.22</td>
<td>-4.40(47)***</td>
<td>0.48</td>
</tr>
</tbody>
</table>

Note: df = 47; *\(p < .05\). **\(p < .01\). ***\(p < .001\).
Table 8.1
Study 1 – Immediate-Post Survey: List of All Open-Ended Responses to “I feel that attending this training will make a difference in the way I do my job.”

- Although a large majority of the population I encounter is not transgender, this training provided me with tips and tools to help ensure that I am providing the best possible care.
- Although I think I already was doing a good job, this training taught me more about transgender care.
- Being aware of gender neutral language is something I need to work on.
- Being more aware.
- Being more knowledgeable is the first step to making a difference.
- Changes how I view others initially.
- Especially [concerning] pronouns and which people identify [with].
- Gave me ideas how to be more open & to use gender neutral language when talking with patients.
- Helped to further educate me, so I can understand the struggles they face.
- I always try to treat everyone with respect but now I have more information to better do that.
- I am able to approach people in a welcoming manner and am more aware of the population.
- I am more aware of the difficulties & I am better prepared to make a safe, welcoming environment.
- I am more [knowledgeable] about this subject now.
- I am now more educated and equipped with tools to make a difference.
- I did not know much about this topic and feel much more comfortable.
- I feel like I am in inclusive person & do a fairly good job about respecting people. This training will make me be more careful about the words I say - such as "sir" + "ma'am."
- I feel more comfortable having the knowledge on how to treat patients
- I feel more confident in my knowledge.
- I feel more prepared to help transgender people without making them uncomfortable.
- I have a better understanding.
- I have a better understanding of challenges that face the trans-community regarding healthcare.
- I have not had training in transgender studies before.
- I have read a lot and am somewhat familiar with the community, and not a lot of info is new.
- I learned a lot of valuable information.
• I learned [a lot], especially about not only asking certain questions, such as "are you pregnant" to those who look like a women.
• I need to learn more about the subject.
• I now know correct pronouns.
• I planned to be inclusive in my practice before this.
• I see + talk to hundreds of people at work. I don't have time to sit down & discuss this right now. I'll quickly answer questions and the move on to the next person.
• I think it gave me new ideas on how I can best care for my trans patients.
• I think it will make me more open to trans [patients].
• I think that this provided good reminders and potential talking points.
• I think this training will help me be more thoughtful & respectful to my patients.
• I typically try to avoid the conversation, but this made me feel that they may want/at least appreciate the open [conversations] about it.
• I will be able to approach trans patients in a more natural manner now.
• I will be as open as I can be with my current knowledge of transgender people, and ask them what they need from me.
• I will be more comfortable adding the necessary questions in order to gather the appropriate information.
• I will be more conscious of the assumptions I make and pronouns I use.
• I will keep the information in mind when interacting with patient and be more of an advocate instead of a silent supporter.
• I will try to be more gender neutral when talking to patients.
• I would love to implement diverse questions on paperwork so health care providers can provide the best care possible for all patients.
• I would've treated them the same regardless.
• In the pharmacy community setting, I feel more comfortable to address questions that may be necessary to provide the best care for transgender individuals.
• It gave insight into challenges transgender persons face & how I can help
• It was nice to hear that it is okay if you make a mistake. I get so nervous about offending people.
• It was nice to hear the perspective of [someone] who has been through this experience.
• It will help me because I know not to treat transgender people any different. I will just need to brush up on hormone dosing. This training opened my eyes about the struggles & will help me become more empathetic.
• It will make me more gender neutral in general to be able to make all my patient's comfortable.
• Just a quick overview.
• Knowing more about the process and struggle they go through makes me confident that I do not want to be another obstacle.
• Knowing there are known unknowns, unknown knowns, known knowns, and unknown unknowns allow me to be conscious of how I'm treating my patients.
• Knowledge and experience always helps to better care for patients.
• Make me more aware of how I may be assuming things about patients.
• Maybe keep a more open mind.
• More confident in talking to LGBT.
• More knowledge about things, I may not know how to help but be cognitive that they may need extra care.
• Not sure. In the hospital setting, I haven't encountered transgender patients relatively, but this is good info to know.
• Professional care is provided to all patients regardless of my views.
• The additional [exposure] will help me provide context to how I approach patients.
• The more I am exposed, the more confident I feel.
• There were tips & tricks that I found to be applicable & would like to implement.
• This has made me aware of small things I can do to make a difference.
• This information is so important in healthcare to be able to distinguish from these terms + provide appropriate care to our patients.
• Using different terms when interacting [with] patients.
• While I am familiar with this topic and have a handful of gender-queer/gender-fluid friends, learning more will always improve the care I provide.
• Will use more gender neutral terms like "partner" rather than husband, etc.
• Would like to hear more on statistics. How many transgenders [sic] on average regret their decision?

Note: Responses are verbatim.
<table>
<thead>
<tr>
<th>Study 2 – Immediate-Post Survey: List of All Open-Ended Responses to “I feel that attending this training will make a difference in the way I do my job.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• As a trans-affirmative psychologist with training and experience, I loved this presentation as a great introduction that I will assign to my interns (9) and residents (8). Thank you!</td>
</tr>
<tr>
<td>• As an Immunization RN I don't really need to know if a patient is transgender. If they share that great but it will not impact my role as their healthcare provider in any way.</td>
</tr>
<tr>
<td>• At my current job I have had no specific training to provide Trans-centered care, this has been helpful. I do think my workplace should include this sort of training in the on-boarding process for new employees, and I am more likely now to point that out to my supervisor.</td>
</tr>
<tr>
<td>• Because it has provided me information about the transgender population I needed to refresh to work affirmatively with my patients.</td>
</tr>
<tr>
<td>• Better understanding.</td>
</tr>
<tr>
<td>• Concrete examples of ways to make an immediate impact on improving healthcare, such as improving paperwork and [EMRs] and having all gender bathrooms available.</td>
</tr>
<tr>
<td>• Correct phrasing of questions and such was a good review!</td>
</tr>
<tr>
<td>• I already felt fairly educated about differences between sex/gender/sexuality but I think this training did an excellent job of summarizing those. I learned a lot about barriers to healthcare and specific rules/ways the system works that further create health disparities.</td>
</tr>
<tr>
<td>• I am a better trans-informed provider following this training. But even prior, I believe all individuals can and should be treated with respect and dignity.</td>
</tr>
<tr>
<td>• I am more comfortable with knowing which questions to ask to be more trans-affirmative. I also now have ideas that will start to help to make our facility more welcoming and safe for the trans population.</td>
</tr>
<tr>
<td>• I am motivated to be more open about being trans-affirmative. I’ve also purchased a pin to wear on my badge in hopes that I will be more approachable to members/patients who identify as part of the LGBTQIA community.</td>
</tr>
<tr>
<td>• I am still just a doctorate student, in a program that does not acknowledge sexuality and gender diversity. However, I will continue to do my own research and push our faculty to actually get educated themselves.</td>
</tr>
<tr>
<td>• I appreciate the sentiment of making my clinic an affirming place for all individuals. We are all people, and should be seen and respected as such. This training helps to fill some of my knowledge gaps in affirmative care for trans individuals. Now I am more aware, and will not make assumptions!</td>
</tr>
</tbody>
</table>
I appreciate your concrete examples of ways to improve one's practice (e.g. gender neutral bathrooms and diverse magazines in lobby). I think language is hugely important in providing trans affirmative care and this training confirmed that.

I appreciated the suggestions on how to phrase questions or broach subjects in a gender-affirming manner.

I did not know the term cisgender. I also did not know sex vs gender information.

I do feel that I had a decent knowledge on this topic prior to this training, but it is a great refresher to remind myself the barriers these folks have to obtain healthcare and how to be more welcoming. I work mostly with folks who are homeless, and I see so often how skewed the numbers are for LGBTQ folks. More knowledge on how to help this population is always welcomed.

I do feel that this training will affect the way I do my job. I am at the front desk and want the first impression of our clinic to be open and welcoming to all who come here.

I don't work with patients in a healthcare setting but I do work with residents within my county. I think it is important for all people to understand the disparities that this communities faces and this training will help me and my coworkers treat all people with the same respect.

I feel confident that I can make changes to make all patients, including those that identify as transgender, feel more welcome in a healthcare setting. I would never want to make a patient feel unwanted or ashamed and I feel like this training helped provide me with tools to ensure I create a positive environment.

I feel like I would need to change some things like the forms and perhaps bathrooms to make it more accommodating and inclusive.

I feel like there are changes that need to be made in our workplace (such as a gender neutral bathroom or non-discrimination clauses) but I am not in a position of power to make these changes. Obviously, by making this training available to staff, our workplace is trying to move forward but it would nice to see some other more visible efforts of change.

I feel more comfortable asking questions and understanding the transgender patient.

I feel more confident in caring for my trans patients even if I don't have all the answers.

I feel that attending this training will make a difference in the way I do my job because it made me more knowledgeable on how to work with transgender patients.
• I had never considered asking the same questions of every patient regardless of gender presentation. This is a great way to both normalize and advocate for trans-folks.
• I have been fortunate to attend one of Oak's trainings previously and also learned a lot in my graduate program. Still, I pick up new ideas each time I attend training. Thank you Oak and my best to you in the dissertation process!
• I have done trainings in the past about transgender care, and I also have experience with close family members transitioning. I feel like I treat people like people! So I can't say that I would "change" my practice, but I absolutely agree that this is important for people to know about and feel comfortable talking to their patients about, especially as more transgender individuals are able to express themselves more freely.
• I have felt very accepting toward but uneducated regarding transgender individuals and glad to know more terminology and advice on how I can best treat them.
• I have personal experience and understanding of Trans identities, but what I lacked what generalizable professional protocol.
• I have worked with transgender individuals in the past so I feel as though I was aware of a lot of the content covered in this training, however, there is always room for improvement and this training helped remind me of how even the smallest changes can make a difference.
• I learned more about barriers and challenges faced by transgender individuals. As a counselor in training, this makes a difference because I don't want to rely on a client to explain every barrier to me. It will help me be more understanding and to not put clients in educator roles.
• I now have the baseline terminology and knowledge that will allow me to be more sensitive and welcoming to this population or those transitioning into this population.
• I now want to get in the habit of asking everyone the same questions in the same way so that it doesn’t feel weird when asking someone who is transgender.
• I think being able to effectively communicate with people of all genders, especially in regards to pronouns they may prefer, is important. This helped educate me on that topic in particular.
• I think that this training will make me more informed to do my job and support other providers in doing their job confidently and appropriately. I feel that I will be a better advocate for trans individuals in getting their needs met.
• I try to treat all people with respect already.
• I understand more of the difficulties that transgender people face in the healthcare system, and ways to make my practice environment more welcoming.
• I will ask questions like "How can I help you?" instead of "how can I help you sir?". I will also ask more questions that let clients explain themselves to me instead of assuming.
• I will be more careful about the language I use and being aware of if it contains assumptions.
• I will begin asking patients which pronouns they prefer and also be more liberal in my use of "they" in written and spoken contexts.
• I will create a routine practice of creating a more welcoming environment by choosing different language and asking everyone about identity and behaviors.
• I will start asking question about what gender consumers identify as, preferred pronouns, name etc. on a regular basis with all consumers and no longer make assumptions based on looks, name given etc. I will learn to point out to all consumers where single stall restrooms are in the building, and advocate for policy changes to allow for preferred names to be used in consumer record so individual can be called by the name they choose.
• I will use this training for more of the staff I work with. I am also sharing on RHAP MT list serve which helps educate new learners/physician on all kinds of issues they may face in their new rural MT clinics. Great resource.
• I work primarily with children, but still found this to be a great training! Good and useful information and nicely presented.
• I work with youth involved in the juvenile justice system and noticed ways in which our program has been more categorical in nature than we'd like. For example, recently we participated in the Girls on the Run 5k, we did not offer to every youth in our program, only those whose sex is female. In retrospect, I would've offered to every youth and allowed them to decide if they want to participate.
• I'm currently working with kids, so I'm not entirely confident I can utilize this exactly the same. But I thought that the thoughts on normalizing asking preferred names and pronouns to EVERYONE is a super easy and thoughtful thing to do, as well as creating an office space that includes some inclusive aspects is another way to simply create a welcoming and safer environment.
• If I work with someone who is transgender I am hoping to have more confidence now in learning if they are willing to disclose information.
• In Pediatric Endocrinology I will be working with the transgender community, thank you for making me more aware of how I can be more inclusive. Additionally this presentation gave me "action items."
• In the mental health profession we are often encouraged to refer clients who may be "outside our area of expertise," but it is important to recognize a referral could be an additional barrier.
• It helps me be more aware of my personal biases.
• It is hard to determine how, without knowing where I will be practicing, but at the very least I will make my clinic safe and welcoming to all people and facilitate the ability of patients and colleagues alike to express themselves as they need.
• It was a good lesson that even though medically an individual may present to you with their chosen identity, as a medical professional one may still have to screen with issues present to their birth sex, such as pregnancy testing. In addition, I was unaware about issues with insurance and identification sources such as their drivers license or birth certificates.
• It was engaging and helped me understand that merely being open to asking questions and learning from my clients could be a huge step forward.
• It was good information, I just don't get the opportunity to use it that much.
• It was helpful to learn that I don't necessarily have to be an expert to provide transgender affirming care. That was the main barrier for me providing that care, I believe.
• It will make me more aware of public health practices in the office.
• It's impacted how I phrase my intake questions and to think about using more gender neutral terms and language. I've put a preferred email on my signature also now.
• Lots of ideas that I can easily integrate into my day-to-day interactions with patients.
• Many of the topics covered were things I am already familiar with and it is always great to have a refresher to spark reflection and help me think about the ways I provide care and determine if my actions match my values.
• My job does not involve direct patient contact, but I would like to help educate others on the clinical team when appropriate.
• My patients have only been cisgender females to-date; even if my patient population remains only cisgender, I like the concept of introducing them to the inclusivity of pronouns so that they may increase awareness amongst their circle of influence.
• My understanding of transgender clients has grown. I am always seeking ways that I can help my clients feel accepted and comfortable.
• Thank you Oak, I thought this was wonderful...the more we know the more we can all live together and take care of each other.
• The Quote from Dr. Joey Banks was a simple reminder that sometimes in our attempts to be sensitive and perform within the limits of our competency, we can often times do a disservice to the people that need our help.
• The training presented, in a short amount of time, a thorough overview of salient information regarding transgender individuals seeking health care in a conversational and accepting manner with many helpful suggestions for providers.
• This has helped to understand and be more knowledgeable about the physical impacts and obstacles that a trans gender person may have including care and insurance, how to help address care, and create a more comfortable environment.
• This is the first transgender training I've had. I think there is a lot more to learn.
• This is the second or third time I've gone through Oak's training. It's been great every time. Oak's training has helped me identify and start addressing my own biases. The training has reaffirmed my belief that these are conversations our team needs to be having in order to make everyone who enters through our doors feel welcome and safe, and it's also given me more confidence to speak up and push for changes internally.
• This training has clarified some myths that I have heard. I will be more confident in asking questions due to not understanding and not feel ashamed that I must ask.
• This training made me more aware of the barriers trans individual's face within the healthcare system and how to help combat those dividers.
• This was a nice, concise introduction to communication, signals, and awareness that I had not previously consolidated in this way. Thank you!
• This was helpful to learn what I can do as a future health care professional to promote inclusivity for the transgender population. Having a better understanding of the barriers to quality health care will help me recognize where these health disparities can be narrowed in my future clinical practice!
• Very informative. It would be nice to have a documentary with this training done and shown on national television. There are just too many people with misunderstanding and preconceptions that need to be uprooted to bring people who are trans into a just and fair world. Thank you for this fine efforts. I have a 21 year old son who has taught me [a lot] about sex, gender and sexual orientation. He came out as a gay man his freshman year of college and became active in his college's LGBTQ+ organization. The thought that a family would shun or disown their child is heartbreaking. The world has so much to learn and this is a step. I keep learning and apologize often for not
knowing or speaking in error. Being humble and contrite will go along way in change. Thank you for sharing some of your history. Keep up the momentum!

- Very well done with clear facts and important distinctions. I really didn't even understand the definitions prior to this training and have been a medical provider for decades.
- We may need to change our questionnaire about pregnancy before giving immunizations.
- While I felt I had a good idea about the use of some of these terms, i.e., sex, gender, there were some aspects of how these terms should and shouldn't be used that I wasn't fully aware of. I have always thought that gender and sexuality had a strong genetic component, therefore while there are choice involved, in how we express ourselves, there is the component of "born like this". I thought the training was solid, very personal able and interesting. I appreciated the disclosure, it made the training much more emotional for me. I will be more assertively pro-active in how I approach this topic with clients.

Note: Responses are verbatim.
Table 9.1

*Study 1 – Immediate-Post Survey: List of All Open-Ended Responses to “This training has increased my knowledge on how to work with transgender patients.”*

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>As stated above. I can use more gender neutral language. As well as asking open ended question to help with the conversations.</td>
</tr>
<tr>
<td>Being more aware.</td>
</tr>
<tr>
<td>[Definitely] increased my knowledge.</td>
</tr>
<tr>
<td>Even just knowing the correct lingo is helpful.</td>
</tr>
<tr>
<td>Everyone is different, but this helped understand more of how they're feeling &amp; previous struggles in health care that might've affected them negatively.</td>
</tr>
<tr>
<td>Good reminders about how to treat transgender pt.</td>
</tr>
<tr>
<td>Got more details.</td>
</tr>
<tr>
<td>Helped me learn about the insurance trouble that they can face.</td>
</tr>
<tr>
<td>I did not know before that transgender individuals had to go through such a long &amp; complicated process through the courts, etc.</td>
</tr>
<tr>
<td>I did not know much going into this.</td>
</tr>
<tr>
<td>I didn't really have much knowledge.</td>
</tr>
<tr>
<td>I feel a bit better on what I can do as a future medical professional.</td>
</tr>
<tr>
<td>I feel I have more understanding towards treating our trans-patients, and understand how much more there is to learn out there.</td>
</tr>
<tr>
<td>I feel [knowledgeable] about the subject &amp; it doesn't make me feel as uncomfortable.</td>
</tr>
<tr>
<td>I feel that I have a better understanding of why they feel the way they do when coming to HCP.</td>
</tr>
<tr>
<td>I know a lot more about the struggles &amp; [prejudice] they face.</td>
</tr>
</tbody>
</table>

*Note: Responses are verbatim.*
Table 9.2
Study 2 – Immediate-Post Survey: List of All Open-Ended Responses to “This training has increased my knowledge on how to work with transgender patients.”

- Additionally, I appreciate the awareness you brought regarding the unique challenges and barriers that trans folks may face with respect to primary care/routine medical care.
- As a mental health provider, I do not have as much training in talking about anatomy (of anyone except in rare circumstances). I appreciated learning more about way to ask about anatomy appropriately if it is relevant to what I am working on with a patient.
- Before this, I didn't know what was appropriate to ask and how to ask various questions. I feel like I was given a lot of great tools as well as different perspectives to consider in my healthcare practice.
- By making paperwork and sex/gender Questions universal for all patients this helps me to make fewer assumptions and to also help advocate for this population.
- Clear and helpful didactics and also suggestions.
- Clear descriptors with simple infographics is nice.
- Creating conversation about transition, feeling empowered to offer resources and support.
- Emphasizing on the fact that their health care is almost the same as the rest of population. Just a few [differences]. But being open, curious, sensitive and respectful is key. Like any culturally and sexually diverse population.
- Even though I don't see patients, I do chat with employees. Learning different ways to phrase questions helps in multiple situations.
- I am more aware of the difficulties and issues that patients who are transgender may run into with their healthcare, and of easy solutions that I can implement with all patients to make their healthcare experience better.
- I appreciate the information on insurance issues - I was not aware of these issues before.
- I definitely feel more confident that I have skills to work with transgender individuals, but that I also need more support and training. I'm a huge believer that there should be no wrong door so I wouldn't be speedily referring others out from primary care without attempting to work collaboratively with the individual, the care team etc. to see if we can make changes to mean we don't need to close a door.
- I didn't know anything about treating transgender patients before this training. I also do not work in a clinical environment.
- I don't feel I necessarily learned anything I didn't already know.
• I feel comfortable working with the trans community so this training is like preaching to the choir but am so glad to have it! Thank you!!
• I had a few misconceptions regarding transition, specifically typical age of transition, which the presentation dispelled. Moreover, I had not had previous formal exposure to use of pronouns, so that was helpful in the knowledge category as well.
• I have had experience in other health care settings working with colleagues, mentors, and clients who are transgender, so I do feel like I took this training with a decent knowledge and experience base.
• I have learned many new things about transgender.
• I haven't actually worked with a transgender patient so it's difficult for me to say but I feel I know more than before.
• I knew there were barriers in healthcare, but this opened my eyes that much more. It has showed me ways in which I can advocate and also understand why in some instances they may be hesitant or uncomfortable.
• I learned a lot about healthcare disparities and barriers to care. I was surprised by some of the hoops that individuals still have to jump through to even get a medical provider to discuss transgender care with them.
• I learned more about the barriers that transgender patients face to [health care].
• I like that you talked about that this should be a continuous process rather than simply checking the trans box once someone has shared their identity once.
• I read a different training guide prior and this video reiterated many of the principles. So I learned some things, and further cemented others.
• I think it helped me think through possible language that can be problematic or language that I could use.
• I understand more of the barriers that the transgender community encounters.
• I understand some of the challenges that they face and can better help make sure they get the same level of care.
• I was already aware of a lot of the basics, such as difference between sex, gender, and sexuality but I was still able to learn some very helpful things.
• I was not aware that the suicide rate for transgender individuals was so high.
• I've worked primarily in labor and delivery, so I had never really thought about how to best ask about gender and sex and ensure that patients are receiving the appropriate care. It's so important to ensure that patients are having their needs met, regardless of what body parts they have or don't or how they see themselves as male, female, or asexual. Asking people up front may seem forward or uncomfortable, but it is something that we need to incorporate into our "scripts" so to speak so that transgender persons may feel more comfortable talking about it as well as get their needs met.
• It definitely did, although again, I work with kids right now so I would love to hear more on working with kids who are questioning and/or [transitioning].
• Keeping in mind that anatomy is anatomy no matter gender identification is practical in the initial approach and then asking what might make an individual more comfortable during an exam is useful to both of us.
• Like all clients, it is important to ask about, and respect individual differences.
• Mostly due to the descriptions of exclusion, disrespect, and risks encountered as transgendered patients seek health care services.
• New ideas and reinforcement of prior related information previously learned were presented.
• Not use specific pronouns... Ask don't assume.
• Provided me with a broader experience of what this population has to face, so that in case I have a client in the future, I may more quickly show understanding and empathy of their experiences.
• Really just reinforced what I already believed as far as asking questions and being a good listener.
• Resources were great!
• Reviewing terminology, care, etc.
• See above. I am a little more confident in the terminology.
• Specifically, there were questions I would have been unsure of how to approach, such as regarding someone's anatomy, and this helped clarify a way to ask about potentially sensitive topics if/when necessary.
• Thank you so much for doing this training. I feel I have learned a lot and can better understand our transgender patients and communicate better to them so that they feel comfortable and welcome in our clinic.
• The organizational strategy was helpful.
• The presentation broke down very concrete ideas about how to have supportive conversations, ask the right kinds of questions, and reduce language that makes a lot of unnecessary assumptions.
• The tangible ways presented to help make everyone feel comfortable was really helpful - not assuming categories, asking about anatomy, asking about "current gender identify" as it is fluid, I did not know the difference between cis & trans.
• The training gave me [verbiage] and phrases that I can use to make questions I ask more inclusive.
• This training has been extremely helpful in clarifying terminology and the difficulty/discrimination that trans individuals face.
• This training has helped in that it's given me more confidence in speaking up internally about ways our org can be a more inclusive, welcoming, and safer place for transgender guests. We still have a long ways to go, but, thanks to
this training, our team has started making changes to its program/facility and we're taking every small change as a win!

- This training has helped me to understand things better.
- This training has helped with proper verbiage and stigmas.
- This training has increased my knowledge in how to support a transgender patient navigate a medical setting, and how to support coworkers in using supportive language and care.
- Though I would consider my knowledge base in this area to be "pretty knowledgeable" already, I appreciated the wealth of conversation that was presented. It's always great to remind myself and be refreshed on this information that is critical to quality care.
- Understanding the best questions to ask without offending has been helpful. I overthink it sometimes, but just need more exposure to these situations and interactions in clinical practice.
- Understanding the challenges that trans individuals face is helpful in determining how best to provide best care. I feel more comfortable with the knowledge I now have vs before this training.

- You helped to answer some questions I had. Everyone should see this video.

*Note: Responses are verbatim.*
Table 10.1
Study 1 – Immediate-Post Survey: List of All Open-Ended Responses to “This training has increased my confidence in working with transgender patients.”

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was always pretty confident.</td>
</tr>
<tr>
<td>Again, I don't encounter many transgender patients so not much experience.</td>
</tr>
<tr>
<td>Although I know I still have a lot to learn, this training was very insightful &amp; informative.</td>
</tr>
<tr>
<td>Because I have some hesitancies or disagreements in some areas, I feel that I am painted as a &quot;bad health care provider.&quot;</td>
</tr>
<tr>
<td>did not change confidence.</td>
</tr>
<tr>
<td>I always can learn more and become more confident.</td>
</tr>
<tr>
<td>I am inclusive, but I still feel uneasy managing certain therapy.</td>
</tr>
<tr>
<td>I feel comfortable working with trans patients, because I feel confident that I can help create a therapeutic regimen to get them what they want.</td>
</tr>
<tr>
<td>I feel I better know how to address the situation.</td>
</tr>
<tr>
<td>I feel I know more about what transgendered individuals go through.</td>
</tr>
<tr>
<td>I feel like I can feel comfortable explaining I’m not an expert but I will try my best to give appropriate care.</td>
</tr>
<tr>
<td>I feel like I [learned] a lot but have a ways to go.</td>
</tr>
<tr>
<td>I feel like I will be able to help them better by knowing more about their struggles. I don't want to make them any more uncomfortable than other might have.</td>
</tr>
<tr>
<td>I feel more comfortable about it.</td>
</tr>
<tr>
<td>I feel there is still a ton of information to learn.</td>
</tr>
<tr>
<td>I guess I didn’t know how to act before and this gave me confidence to just act normal and work with them just like anyone else.</td>
</tr>
<tr>
<td>I know I still have gaps but now I know to be more open, ask more gender [neutral] &amp; steer the patient to tell me their preferences.</td>
</tr>
</tbody>
</table>

Note: Responses are verbatim.
<table>
<thead>
<tr>
<th>Study 2 – Immediate-Post Survey: List of All Open-Ended Responses to “This training has increased my confidence in working with transgender patients.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Again, just realizing that I don't necessarily need to be an expert to provide trans-affirmative care. In fact it made me want to gain more knowledge in becoming a trans-affirmative provider.</td>
</tr>
<tr>
<td>• Again, need more exposure, practice.</td>
</tr>
<tr>
<td>• As silly as this sounds, I sometimes feel that I get more nervous about &quot;messing up&quot; when I first get more or new information on a topic. So right now I'm in that nervous phase, but I also know that more information has always helped me in the long run and, hopefully, allowed me to be a better coworker/friend/community member to others.</td>
</tr>
<tr>
<td>• Confidence comes with experience and though education is comforting I will feel more confident as I have more professional interactions.</td>
</tr>
<tr>
<td>• Do to the information as noted above.</td>
</tr>
<tr>
<td>• Every time I learn more about vulnerable populations, I feel more confident in my ability to meet their needs.</td>
</tr>
<tr>
<td>• Having language and ideas of how to be inclusive are helpful and make me feel more capable of creating a welcoming therapeutic space.</td>
</tr>
<tr>
<td>• Having strategies to put in place increases my confidence.</td>
</tr>
<tr>
<td>• Hearing that the educator also slips up in how he refers to other people and that it is not a big deal was reassuring.</td>
</tr>
<tr>
<td>• Honestly it's reassuring to hear &quot;if you get it wrong, apologize and move on.&quot; There are times where I've worried about using wrong names or pronouns, and it's good to know that many trans people won't take offence as long as you apologize and correct it!</td>
</tr>
<tr>
<td>• I appreciated the language provided to ask about pronouns, gender identity, anatomy, and past surgeries.</td>
</tr>
<tr>
<td>• I believe confidence will be determined once I actually have a client.</td>
</tr>
<tr>
<td>• I can be more mindful when caring for transgender community. Thank you for giving me examples of how to ask different questions.</td>
</tr>
<tr>
<td>• I definitely feel more confident that it will be ok to make some mistakes with transgender folks if I am open and affirming with them and work to rectify them. I like to work collaboratively but I feel more confident in having a better understanding of small changes to make to respect the uniqueness of these individuals.</td>
</tr>
<tr>
<td>• I do not work with patients.</td>
</tr>
<tr>
<td>• I feel better about coming across someone who is transgender and working with them.</td>
</tr>
</tbody>
</table>
• I feel better about the language I can use with our patients as a whole to use neutral terms and to never assume what gender someone may identify as just on how they look.
• I feel better prepared to ask questions.
• I feel better prepared with intake paperwork and employee training to avoid awkwardness and discomfort due to misgendering or using the wrong name etc.
• I feel like I could call upon this knowledge easily when treating an individual that identifies as transgender. I feel more confident in my ability to meet the needs of these patients.
• I feel more comfortable asking which pronouns are preferred. It feels easy and appropriate for individuals who are both trans- and cis-gendered.
• I feel more confident to be able to ask the right questions as they are necessary for patients' healthcare needs.
• I felt hesitant before the training to say I would work with a transgender individual and not refer them, because I was worried about myself not being an expert in trans affirmative care and not being the best person to help. However, this training helped me realize that alone is a barrier for many trans individuals. I feel more confident now that I could provide care to a trans individual, as long as I keep an open mind to their experiences.
• I have a better sense of good questions to ask to direct a conversation in the way it needs to in order to determine what care is needed for a particular patient without being invasive.
• I have been uncertain of asking clarification questions due to not wanting to offend patients. I now know this is preferred.
• I have confidence that I am a welcoming, open person and I now know some more things which I can do to further instill that, but I think some experience would do me well.
• I hope to make ALL of my patient's feel comfortable seeking care from me.
• I know I will make mistakes, but I hope I can convey my respect for the individual no matter what.
• I know more than before but I haven't worked with transgender patients so I can't actually say.
• I learned a lot about what to ask and the correct terminology to use to be respectful of this population and my transgender friends.
• I think I always feel that I don't have enough information to care for my trans patients but I probably can do a lot for them and get more assistance when I need it.
• I think it increased my confidence because I know I approach this topic with an open mind and an open heart, and am always accepting and never judgmental.
• I think part of being trans-affirmative means revisiting and learning continuously to better serve this population.
• I think this training, especially from the perspective of a transgender individual in the health care field, has been very impactful to increase my confidence in working with this population. If the delivery had not been from an individual who identified as transgender I wouldn't have felt as confident in the advice for how to approach certain situations in the most accepting, respectful, welcoming manner. Thank you!
• I was reassured by the idea that everyone can become a trans specialist.
• Increasing those knowledge building blocks = more confidence to put into practice.
• Intent and impact are different. It is helpful to be reminded to be open in communication and not pretend to be an expert.
• It has been some time since I (knowingly) interacted with someone who identifies as Trans, so it is a good reminder of things to keep in mind.
• It was a good intro but I don't know that I would treat anyone transgender drastically different.
• It was validating to hear that we already know the majority of what we need to know to be effective with trans individuals, and makes me feel more confident in being able to be a competent trans-affirmative provider.
• It will take intentional practice and reflection on practice delivered. Having a team around you who is like minded will help.
• It's definitely increased my knowledge and awareness of ways to be more inclusive and welcoming, I think confidence will come as that information is utilized more and more.
• Knowing what issues are important to address.
• My confidence has been increased by the acknowledgement that it is okay to make mistakes, be incorrect and be corrected when talking to a transgender person.
• Particularly in medical settings (in which I am interested in doing work), it seems really important to know about the types of stressors trans individuals may face in these contexts, as well as how I can be an advocate and an ally to trans individuals by voicing the need for changes with respect to forms, practices, and approaches to increase the likelihood of receiving affirmative care in that context.
• So much, now I can confidently talk about it.
• The extra knowledge will help shape how I interact with transgender individuals, but reestablishing long-held habits and behaviors regarding communication (i.e., use of pronouns) that have been shaped by many years of growing up in Montana (and society in general) will take actual practice.
• The more you hear about, talk about and learn in regards to minority communities, comfort and confidence can grow.
• The training reinforced much of the knowledge I already had - helping me to feel more confident in what I know and how to deliver sensitive and competent care. Also, the acknowledgement that we all can make mistakes in our language, etc. was very helpful as my worry about making a mistake or saying something that offends can be inhibiting times.
• The training was very informative, however my current practice at a college counseling center requires occasional training about how to be LGBTQ+ welcoming providers.
• There really is no specialty mental health training needed to work with someone who is transgender, the disorders would need similar treatment, empathy, understanding, normalizing their experience and helping them to find ways to address their experiences that empower them. The nuances of how being transgender has marginalized their ability to get the support they need would be taken into account only based on their story and being able to help them express how they have experienced life and the ability to be accepted as transgender. Their experience is what I need to acknowledge not assuming the have same experience as any other transgender individual or as any other depressed, anxious, socially isolating individual.
• This training has helped me to be more confident in working with transgender patients by having a better understanding.
• This training provided concrete examples of ways to implement trans-affirmative care into every day practice. I feel that I can confidently implement these examples (gender neutral bathrooms, asking the same questions to all patients) provided.

Note: Responses are verbatim.
Table 11.1
Study 1 – 3-Month Follow-Up Survey: List of All Open-Ended Responses to “I feel that attending the training has made a difference in the way I do my job.”

- A lot has happened since the training, and honestly I do not remember much.
- After starting clinical rotations we have a few patients in our pharmacy who are in the process of transitioning. I feel much more confident and comfortable talking about providing them with the best patient care possible after attending my training.
- As a healthcare provider I will always provide the same education and services I would regardless of the choices a patient makes. I don’t necessarily agree with people choosing to be transgender, but I wouldn’t withhold or do my job any differently if that’s the decision someone makes.
- I am involved in transgender education, advocacy and trainings through my current position. I have several friends and colleagues who are transgender.
- I am not in the current workforce but I am aware of changes I can make when I do begin to practice.
- I believe I am a little more educated from this presentation, and hopefully this information can be shared with the transgender community so they may feel more comfortable with us as health care professionals as well!
- I can only control the way I act and treat people. If people want to make comments then they can do that but I choose to be the better person and not engage in hate speech—especially in a place where I’m expected to be a professional.
- I do not work in an environment where I encounter many transgender patients, but I feel like I will be more appreciative of the challenges they face and their healthcare needs when I do encounter transgender patients.
- I don’t really interact with any transgender population so I haven’t really run into a time when I would use what I have learned.
- I feel more comfortable addressing pronouns and transgender individuals if they wanted to share more of their healthcare with me.
- I feel that at my pharmacy we have created a very inclusive environment. We are willing to help any patient to the best of our ability regardless of how they identify.
- I have always been taught to treat everyone the same. I wish we would have learned more about the medications and how to clinically treat patients.
- I have learned about the aspect of a transgender patient and how to avoid some things that make them feel uncomfortable.
- I haven’t worked too much since the training because of COVID, so I can’t truthfully say whether or not the training has made a difference in how I do my job.
• I know feel like I have more knowledge about transgender, and things that transgender people deal with. Their struggle to get the resources and help they need and how they sometimes don't feel comfortable in situations and might need extra help to enter a situation than most people in health care.
• I learned a lot about how I can ask questions and how I can help transgender individuals overcome some of the difficulties they face.
• I learned a lot more information on how people are treated in healthcare when being transgender and I would like to make a difference for those people.
• I think it has made me more comfortable in the ways that I ask about somebody's gender identity as opposed to their other identities. Especially with drug therapy, there are important counseling points to be made with medications when someone is using them to transition that may not be touched upon if somebody is uncomfortable working with transgender patients.
• I try to treat all people with respect and dignity regardless of my personal feelings and beliefs on transgender tendencies.
• I'm not routinely involved in the care of transgender individuals so nothing much has changed from the training except for my knowledge level.
• Internal and external differences can matter Ex. prostate exams.
• It has made me more aware of the barriers that transgender patients have to overcome for appropriate patient care.
• It has made me more aware of what I say to avoid offending people.
• It’s always nice to be educated about something that is a hot topic in the healthcare world, even though it does not fall into the typical curriculum.
• Most of the information provided I knew already.
• The training made me aware of the challenges that a transgender patient faces every day, especially with insurance.

Note: Responses are verbatim.
Table 11.2

Study 2 – 3-Month Follow-Up Survey: List of All Open-Ended Responses to “I feel that attending the training has made a difference in the way I do my job.”

- It has really helped me feel more confident and comfortable with the language and what to say/not say, how to say it and how to better understand someone going through a transition.
- This training has helped me feel more comfortable having conversations in the workplace. It's also been a good reminder that conversations around trans-affirmative care need to happen. It's important that my organization says we welcome everyone; this training has been a great reminder on how we need to work to make sure that everyone FEELS welcome. I work in a non-traditional healthcare setting. Most if not all neutral answers are because a question is not applicable to my field.
- We are [worrying] in the office to be more transgender friendly from the front office to the back offices.

*Note: Responses are verbatim.*
Table 12.1
Study 2 – 3-Month Follow-Up Survey: List of All Open-Ended Responses to “The training increased my knowledge on how to work with transgender patients.”

- A lot has happened since the training, and honestly I do not remember much.
- I better understand what fears or concerns and issues transgender patients face and can better address these common issues they face in health care.
- I don't really feel that I have to work "differently" with transgender patients. I like to think that I treat all of my patients with respect and someone being transgender doesn't change that. I do think that the training helped me to understand some of the struggles transgender patients go through, which in turn may help me in the future. I also really don't have any way of knowing if a patient is transgender unless they explicitly told me, so therefore I would work with them the same way I work with a cisgender person.
- I felt like I really didn't know much about transgender people or the healthcare they required.
- I have a better idea of how to support my patients better.
- I have learned to separate gender, sex, and sexuality more. I was aware they were different but didn't know how to learn to separate the concepts and understand until this training. I have realized that I have a lot more learning and working on this knowledge in the future.
- I learned a lot during the discussion and what difficulties transgender people encounter and how to help them through those.
- I learned a lot of important information from the lecture.
- I learned more about transgender patients in the training that I could use if presented with the situation.
- I wish I would have learned more about the medication management for transgender patients.
- I would say I still have more to learn, but this course showed me what it means to be transgender.
- In a pharmacy setting, I have seen the insurance struggles transgender individuals often have to go through. I feel better equipped to console those individuals and make them feel more comfortable talking about what we can do next in those situations.
- Just treat them the same as everyone else.
- My stance on this is that I will treat every patient the same, whether they are transgender or not.
- Please see the above elaboration. It’s all about being more comfortable and confident in my own knowledge.
- The presentation was very informative, and also provided insight on how this specific patient population prefer to be referred to in conversation.
• The training provided good information on how to best approach patient care with transgender patients and how to make them more comfortable in healthcare encounters.
• There's plenty more to still learn.
• Understand that I don’t know everything and can learn from them.

Note: Responses are verbatim.
Table 12.2

Study 2 – 3-Month Follow-Up Survey: List of All Open-Ended Responses to “The training increased my knowledge on how to work with transgender patients.”

- I have been doing this medicine a long time- it reminds me how many don’t. It encouraged me to train 4 new Nurse practitioners to provide this care.
- It has helped remind me to treat each person as a unique person with a unique story and not let society get in the way.
- See above, in addition to comfort level in providing services.

*Note: Responses are verbatim.*
Table 13.1

Study 2 – 3-Month Follow-Up Survey: List of All Open-Ended Responses to “The training increased my confidence in working with transgender patients.”

- A lot has happened since the training, and honestly I do not remember much.
- As I haven't worked with any transgender patients after this training, I'm not sure of my confidence level.
- I am not afraid to ask questions regarding transgender individuals and the healthcare they may need that could differ compared to others.
- I do agree, but it was one short training and I feel like there is a lot more to learn and aspects we didn't even touch.
- I do not feel very confident because I haven't used this info much yet.
- I feel more confident working with this population of patient, however would need more practice in these situations clinically before feeling proficient and fully confident.
- I need practice to be confident in using appropriate language and asking appropriate questions.
- I still feel I don’t know enough to give the best care to a transgender patient.
- I want to make sure I never offend someone, and that I can provide them with best care possible.
- It reaffirm what I knew and made sure what I was doing is correct.
- Just a little bit, I already felt pretty confident before the training since I have worked with some of them at the pharmacy.
- Made me realize how much I don’t know, I’ve always just tried to treat people with respect.
- Pretty much the same response as above. However, I now know a little more about some of the transition struggles transgender patients may face, and that may help me to be able to address those issues better.
- With more knowledge, I feel like I am more confident in the patient population as well as being more confident in asking for help.

Note: Responses are verbatim.
Table 13.2
Study 2 – 3-Month Follow-Up Survey: List of All Open-Ended Responses to “The training increased my confidence in working with transgender patients.”

- I always want to do my best to serve patients, and find any information of how to serve patients who identify differently than me very helpful to gain perspective.
- It affirmed I am doing some things right [already].
- See above, in addition to comfort level in providing services.

*Note: Responses are verbatim.*
Figure 1.1

Study 1: Changes in Average Scores of the ATTM as a Function of Time

Note: This figure depicts the changes over time in the average ratings on the ATTM for Study 1. Higher average scores on the ATTM indicate higher levels of awareness of transgender topics (i.e., basic transgender terminology, barriers to care, and affirmative care practices). The dashed line represents participants \( n = 151 \) who participated solely in the pre- and post-surveys. The dotted line represents participants \( n = 48 \) who participated in the pre-, post-, and 3-month follow-up surveys.
Figure 1.2

Study 2: Changes in Average Scores of the ATTM as a Function of Time

Note: This figure depicts the changes over time in the average ratings on the ATTM for Study 2. Higher average scores on the ATTM indicate higher levels of awareness of transgender topics (i.e., basic transgender terminology, barriers to care, and affirmative care practices). The dashed line represents participants \( n = 138 \) who participated solely in the pre- and post-surveys. The dotted line represents participants \( n = 48 \) who participated in the pre-, post-, and 3-month follow-up surveys.
Figure 2.1

Study 1: Changes in Average Scores of the ATPS as a Function of Time

Note: This figure depicts the changes over time in the average ratings on the ATPS for Study 1. Higher average scores on the ATPS indicate higher levels of anti-transgender prejudice. The dashed line represents participants (n = 151) who participated solely in the pre- and post-surveys. The dotted line represents participants (n = 48) who participated in the pre-, post-, and 3-month follow-up surveys.
Study 2: Changes in Average Scores of the ATPS as a Function of Time

Note: This figure depicts the changes over time in the average ratings on the ATPS for Study 2. Higher average scores on the ATPS indicate higher levels of anti-transgender prejudice. The dashed line represents participants \((n = 138)\) who participated solely in the pre- and post-surveys. The dotted line represents participants \((n = 48)\) who participated in the pre-, post-, and 3-month follow-up surveys.